MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 126-a

01846

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 days
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6752 McArthur Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William H. Abbott

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 19, 1860

8. AGE: Years	Months	Days	If less than one day
84	11	16	hrs. min.

9. Birthplace: Waukegan, Illinois (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: Martin Abbott
13. Birthplace: Washington, Massachusetts
MOTHER 14. Maiden name: Ellen M. Kempton
15. Birthplace: Hebron, Connecticut
16. Informant: Hospital Records
Address: 7000 block Georgetown Rd, Bethesda, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/5/45 (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director: L. H. Bowes Co.
Address: 901 14th Street
19. 2/5 1945 (Date rec'd by registrar) Wm E. Jackson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1945, at 2:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 29, 1945 to Feb 5, 1945
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Intestinal Obstruction	
Due to Volvulus	
Accidental Fall in Hse. January 2nd, 1945.	
Due to Fibrous Adhesive Bands near 6752 Mac Arthur Boulevard, Washington, D.C.	
Other conditions Terminal Lobular Pneumonia	
(Including pregnancy within 3 months of death) Broken leg, right	

Major findings of operations:
Date of op.:
Autopsy results: See Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of January 2nd, 1945
Where did injury occur? Washington (City or town) D.C. (County) (State)
Injured at home, farm, industry, public place (where?) Public Places
Means of injury Fell, Slip. Injured at work?

23. SIGNATURE: Richard E. Kelso M.D. M. D. or other
Address: 1834 Eye St. N.W. Date signed 2-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

61847

CERTIFICATE OF DEATH

Reg. Dist. No. 2 16

1. PLACE OF DEATH:

County: Suburban Hospital

City or town: Bethesda Mahan

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? two days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? two days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5614 Roosevelt ST.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James Franklin Adams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

8.(b) Name of husband or wife: Lettie Lee

8.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): North Carolina 1870

8. AGE:

Years	Months	Days	If less than one day
74			....hrs. ....min.

9. Birthplace: Elkin N.C.

(Town, county, and state)

10. Usual occupation: Streetcar motorman

11. Industry or business

FATHER

12. Name: Wilson Henry C. Adams

13. Birthplace: North Carolina

MOTHER

14. Maiden name: Wilson Nellie Cook

15. Birthplace: North Carolina

16. Informant: Danville Virginia Wife

Address: 5614 Roosevelt St.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof: Feb 12/45 (month) (day) (year)

Cemetery or crematory: Danville Virginia

Location: Virginia

18. Funeral director: Wm Reuben Tumphrey

Address: 7557 Wis. Ave Bethesda, Md.

19. 2/13 19 45 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEB. 11TH 19 45 at 100 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 45, to February 19 45 and that I last saw h.im alive on February 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	24 hrs
Due to: Arteriosclerotic Heart disease	5 yrs
Due to:	
Other conditions: Paralysis due to cerebral hemorrhage	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. Benjamin, M.D. M. D. or other

Address: Bethesda Md. Date signed 2/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

01848

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County Montgomery — Registration Dist. No. 223

Village or City Takoma Park Md — No. 305 Greenwood Ave St. — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Charles Anderson Sr. If U. S. Veteran, specify WAR ____

(a) Residence: No. 305 Greenwood Ave St. Ward ____

(Usual place of abode) Takoma Park Md. If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Margaret M. Anderson

6. DATE OF BIRTH (month, day, and yeer) Oct. 11, 1870

7. AGE	Yeers	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	74	3	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Inspector - Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. U.S. Q.M.C.

10. Dete deceesed last worked at this occupetion (month and yeer) ____

11. Totel time (yeers) spent in this occupetion ____

12. BIRTHPLACE (city or town) Boston, (State or country) Mass.

FATHER

13. NAME George Anderson

14. BIRTHPLACE (city or town) County Cork (State or country) Ireland.

MOTHER

15. MAIDEN NAME Katherine O'Conner

16. BIRTHPLACE (city or town) County Cork (State or country) Ireland.

17. INFORMANT T. V. Anderson (Address) 305 Garland Ave. Takoma Park, Md.

18. BURIAL, CREMATION, OR REMOVAL Place Forest Glen, Md. Date Feb. 10, 1945.

19. UNDERTAKER Arthur Walters (Address) 734 Eurel St. Takoma Park, D.C.

20. FILED Feb 8, 1945 Worm Dodd Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH February (Month) 8 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan. 1941, to Feb 7, 1945

I last saw him alive on February 7, 1945; death is said to have occurred on the dete stated above, at 12:45 A m.

The PRINCIPAL CAUSE OF DEATH and related ceuses of importance were as follows:

	Date of onset
1. Terminal Bronchial Pneumonia & Pulmonary Congestion	2/5/45
2. Cardio-vascular renal disease	1-6-41
Other Contributory Causes of importance:	
3. Hypertension (from History)	1933
4. Arteriosclerosis	1933

Name of operation ____ Date of ____

Whet test confirmed diagnosis? ____ Wes there an autopsy? ____

23. If death wes due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any wey releted to occupation of deceased? ____

If so, specify ____

(Signed) Francis V. Riplinger M. D.

(Address) 1717 Alaska Ave N.W.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1. Wash 12. D.C.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01849

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Spencerville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lena Anderson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 1, 1870

8. AGE:	Years	Months	Days	If less than one day
	74	4	10	..... hrs. ..... min.

9. Birthplace Highland, Howard Co. Maryland.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business —

FATHER 12. Name John Johnson

13. Birthplace

MOTHER 14. Maiden name Butler

15. Birthplace Howard Co., Maryland.

16. Informant Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 16, 1945 (month) (day) (year)

Cemetery or crematory Spencerville Cemetery

Location Spencerville, Md.

18. Funeral director Robert L. Snyder

Address 246 N. Wash St. Rockville, Md

19. 2-13-1945 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1945, at 8:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6th 1945 to Feb. 11 1945

and that I last saw her alive on Feb. 11 1945

Immediate cause of death	DURATION
A. General Septicaemia	4 days
Due to, or as a consequence of: B. Injury to Rt arm followed by cellulitis	2 wks.
Due to, or as a consequence of: C.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? At Home - Spencerville - Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Chas. E. Tompkinson M. D. or C.

Address Sandy Spring, Md. Date signed 2/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

01850

Reg. Dist. No. 716

1. PLACE OF DEATH:
County Montgomery
City or town Glen Echo Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Five years
Hospital, Institution, or street address where death occurred: Tuscarawas Rd. - Glen Echo Hts.
How long in hospital or institution? At Home Md

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Glen Echo Hts., Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6421 - Tuscarawas Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war — Not Veteran.

3. (a) FULL NAME William Stickle Ardinger

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Annie Amelia Ardinger — 6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) October 2 - 1870

8. AGE: Years	Months	Days	If less than one day
74	4	22	— hrs. — min.

9. Birthplace Williamsport, Md. (Town, county, and state)
10. Usual occupation Blacksmith
11. Industry or business Capitol Transit repair.
FATHER 12. Name Owen Ardinger
13. Birthplace Williamsport, Md
MOTHER 14. Maiden name Ellen Nave
15. Birthplace Williamsport Md.
16. Informant Annie Amelia Ardinger
Address 6421 - Tuscarawas Rd. Glen Echo Hts Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-24-45 (month) (day) (year)
Cemetery or crematory Washington DC
Location
18. Funeral director W. W. Chambers Co.
Address 3072 M St NW
19. 2-24-45 (Date rec'd by registrar) W E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1945 at 10.05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20 - 1943 to Feb. 24 1945 and that I last saw him alive on Feb. 21st 1945

	DURATION
Immediate cause of death Chronic Myocarditis	2 years
Due to Arterio-Sclerosis	3 years
Due to Chronic Nephritis	Unknown
Other conditions Extensive bed-sores	4 months

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wheeler O. Hull M. D. or other
Address Bethesda, Md. Date signed Feb. 24 1945.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

01851

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred: 1917 Rookwood Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1917 Rookwood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: EVA LEE ATWOOD

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	, widowed

6.(b) Name of husband ~~or wife~~: William Milton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 28th. 1868

8. AGE: Years	Months	Days	If less than one day
76	11	23	..... hrs. ..... min.

9. Birthplace: Rockville, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: James Nicholson
13. Birthplace: Maryland
MOTHER 14. Maiden name: Caroline Ward
15. Birthplace: Maryland
16. Informant: Harold W. Atwood (son)
Address: 1917 Rookwood Ave. Sil. Spg.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb - 23 - 1945 (month) (day) (year)
Cemetery or crematory: St Marys
Location: Rockville - Md.
18. Funeral director: Warner E Pumphrey
Address: 8431 Ga Ave. Silver Spring - Md.
19. Feb. 22 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 21st. 1945, at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 4th. 1938 to 2/21/45 and that I last saw her alive on Feb. 21st. 1945

Immediate cause of death	DURATION
Coronary Occlusion	2/20/45
Due to:	
Due to:	
Other conditions: Coronary Occlusion	Nov. '37
Hypertension	15 yrs

(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard Morse Ford M. D. or other
Address: 7 Carroll Ave Takoma Park Date signed: 2/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

61852

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One hour, 45 min.

Hospital, institution, or street address where death occurred:
U. S. Naval Hosp. Bethesda Md.

How long in hospital or institution? One hour 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. New Colonial Hotel 15th & M Sts
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Baby Boy Bailey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2-8-45

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 15 min.

8. Birthplace U S N Hosp Bethesda, Montgomery Co. (Town, county, and state) Maryland.

10. Usual occupation

11. Industry or business

FATHER 12. Name William H. Bailey

FATHER 13. Birthplace Camden New Jersey

MOTHER 14. Maiden name Helen Nelson

MOTHER 15. Birthplace Balaton Minnesota

16. Informant Helen N. Bailey

Address New Colonial Hotel, Wash, D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2-9-45 (month) (day) (year)

Cemetery or crematory George Washington Memorial

Location Hyattsville, Md.

18. Funeral director W. W. Chambers per M.Y.

Address 1400 Chapin St., N.W., Wash., D.C.

19. 7 Feb 8 1945 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~0800~~ 8 Feb. 1945, at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 0645-8 Feb 1945, to 0800 8 Feb 1945 and that I last saw h.. alive on 8 Feb 1945

Immediate cause of death	DURATION
Premature Infant	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Was done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Alvin B Hayden M. D. or other

Address Naval Hosp Bethesda Md Date signed 2/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01853

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
1606 East West Hyway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1606 Est West Hyway
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME JOHN ROBERT. BARRETT

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife: Mary D.a
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 16th. 1856

8. AGE: Years	Months	Days	If less than one day
88	10	2	hrs. min.

9. Birthplace: Canada
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Lumber Industry

FATHER
12. Name: Robert J. Barrett
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret McCue
15. Birthplace: Ireland

16. Informant: Miss Mary Barrett (Daughter)
Address: 1606 E&W Highway, Silver Spg.

17. Removal. Date thereof Feb. 19 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location: New Orleans. La.
18. Funeral director: Adorne & Pumphrey
Address: 8 & 8 Ga Ave - Silver Spring. Md.

19. Feb. 19 1945 Josephine M. Schaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18 1945; at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 16 1945 to Feb. 18 1945 and that I last saw h.... alive on Feb. 17 1945

Immediate cause of death	DURATION
Congestive Heart failure	
Due to: Chronic myocarditis	
Due to:	
Other conditions: Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Marion Bankhead M.D.
M. D. or other
Address: Silver Spring Md. Date signed: 2/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-0 K

01854

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Monty

City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

Street No. 7 Rosemary (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Pearl Lattin Beebe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Lawrence J Beebe

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 11 1884

8. AGE: Years: 60 | Months: 11 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: N.Y. (town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER

12. Name: Carmi Lattin

13. Birthplace: N.Y.

MOTHER

14. Maiden name: Mary C. Thompson

15. Birthplace: N.Y.

16. Informant: Lawrence J Beebe

Address: 7 Rosemary st. Chevy Chase

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-8-45 (month) (day) (year)

Cemetery or crematory: Washington D.C.

Location

18. Funeral director: Geo W Wise Co Inc.

Address: 2200 M st n.w.

19. 2/8 (Date rec'd by registrar) 19 45 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 8 19 45 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 Med Exam. Case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Myocarditis	2 hr.
Due to Carcinoma of intestinal	
Due to tract & Stomach	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brockhurst M.D. M. D. or other

Address: Bethesda Md Date signed 2-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

01855 Reg. Dist. No. 2/8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Rural R.F.D. Derwood md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town R.F.D. Derwood Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Ann Blowers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Andrew T. Blowers

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 1850

8. AGE:

Years	Months	Days	If less than one day
94	9	3	hrs. min.

9. Birthplace Montgomery (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

FATHER

12. Name Ephraim Bell Gaither Sr.

13. Birthplace Montgomery Co Md

MOTHER

14. Maiden name Lydia Upton Allnutt

15. Birthplace Montgomery County Md

16. Informant Mrs. Edith Gaither

Address Derwood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 8 1945 (month) (day) (year)

Cemetery or crematory Laytonsville Md

Location Montgomery Co Md

18. Funeral director Roy W. Barber

Address Laytonsville Md

19. 2/8 1945 (Date rec'd by registrar) L.O. Bell Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1945, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 1945, to Feb 5 1945 and that I last saw h.m. alive on Feb 4th 1945

Immediate cause of death	DURATION
Mitral Coronare disease	Unknown
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Vernon H Dyson MD M. D. or other

Address Laytonsville Md Date signed Feb 8/45

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

01856

CERTIFICATE OF DEATH

Reg. Dist. No. 213

FILM No. G 94 APR 13 1945

1. PLACE OF DEATH:

County Montgomery

City or town 326 E. Monty. Ave Rockville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 81 yrs -

Hospital, Institution, or street address where death occurred: 326 E. Monty. Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Monty

City or town Rockville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 326 E. Monty Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eulalie L. Bowie

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1862

8. AGE: Years 83 82 | Months 2 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name Wm Veirs Bowie, Sr.

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Veirs.

15. Birthplace Maryland.

16. Informant Albert M. Bowie

Address Rockville, Md. (Nephew)

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/7/45 (month) (day) (year)

Cemetery or crematory Rockville Union Cem.

Location Rockville, Md

18. Funeral director Wm Reuben Dempsey

Address 7557 Wis. Ave. Bethesda, Md.

19. 2/5 (Date rec'd by registrar) 19 45 Josephine D. Hutton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1945, at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19.. to Feb. 7 1945

and that I last saw her alive on Jan. 28 1945

Immediate cause of death ..... acute cardiac dilatation

Due to Myocarditis } Senility

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

DURATION
Four months
5 years

Major findings of operations none

Date of op. -

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm R. Smithey M.D. M. D. or other

Address Rockville Md. Date signed 2/7/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

01857

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? one month
Hospital, institution, or street address where death occurred:
US NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? one month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2116 14th St., S. E.,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BOSWELL, Daniel (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 13 June 1884

8. AGE:	Years	Months	Days	If less than one day
	60	9	5	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired Navy Man
11. Industry or business

FATHER
12. Name: ~~deceased~~ Joseph I. Boswell
13. Birthplace: Pr. Geo. Co., Md.

MOTHER
14. Maiden name: ~~deceased~~ Ann V. Adams
15. Birthplace: Pr. Geo. Co., Md.

16. Informant: Nephew: Mr. Sydnor H. Boswell
Address: 2116 14th St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2-21-45 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: Thomas F. Murray
Address: 2007 Nichols Avenue, S. E., Wash., D.C.

19. 19 Feb. 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 Feb. 1945 at 3:40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 Jan 1945 to 18 Feb. 1945 and that I last saw him alive on 17 Feb. 1945

Immediate cause of death	DURATION
Congestive Heart failure.	
Due to arteriosclerotic Heart disease	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles W. Thompson M.D. M. D. or other
Address: US N.H., Bethesda, Md. Date signed: 2-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for adding of age of deceased is shown on FILM No. G 9 4 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01858

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
811 Houston Ave.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 811 Houston Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Miss Nancy Brewer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1871

8. AGE: Years	Months	Days	If less than one day
73y			...hrs. ...min.

9. Birthplace: Wheeler, New York
(Town, county, and state)

10. Usual occupation: Bindery Worker

11. Industry or business: Publishing

FATHER
12. Name: Thomas J. Brewer
13. Birthplace: New York

MOTHER
14. Maiden name: Martha Derrick
15. Birthplace: New York

16. Informant: Washington Sanitarium Records
Address: Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 19, 1945 (month) (day) (year)

Cemetery or crematory: Wheeler Center Cemetery

Location: Wheeler, N. Y.

18. Funeral director: Arthur G. Sellers

Address: 254 Carroll St., Takoma Park, D.C.

19. Feb 15 1945 (Date rec'd by registrar) J. Hilton Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Febraary 14 19 45 at 8:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 19 43 to Feb. 14 19 45 and that I last saw her alive on January 3 19 45

Immediate cause of death	DURATION
Acute Cardial Failure	15min.
Due to: Coronary Occlusion	15min.
Due to: Arteriosclerotic Heart Disease	3½ month
Other conditions: Hypertension	10-15 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Maurice Brewer M.D.
M. D. or other

Address: 45 Carroll Ave. Takoma Pk Maryland Date signed: 2/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01859

Reg. Dist. No. 618

1. PLACE OF DEATH:

County: Montgomery

City or town: Clarksburg Md R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Clarksburg Md R F D

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Laura V. Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 13-August 1927

8. AGE: Years	Months	Days	If less than one day
17	3	22	hrs. min.

9. Birthplace: Montgomery Co Md (Town, county, and state)

10. Usual occupation: Hm Student

11. Industry or business: School

FATHER — 12. Name: Albert Butler

FATHER — 13. Birthplace: Montgomery County

MOTHER — 14. Maiden name: Ethel May Brown

MOTHER — 15. Birthplace: Montgomery Co Md

16. Informant: William Brown

Address: Clarksburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 11-1945 (month) (day) (year)

Cemetery or crematory: John Wesley

Location: Clarksburg Md

18. Funeral director: Roy W Barber

Address: Gaithersburg Md

19. 2/10 1945 R D Bell Dept. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 8 1945 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6 1945 to Feb 8 1945

and that I last saw h... alive on Feb 8 1945

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to:	
Sepsis	
Due to:	
Other conditions: Abscess of Heart	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Gaithersburg Md Date signed: Feb 10, 1945

(M)

MARGIN RESERVED FOR BINDING

(I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

01860

CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: R F D Brookville no
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? fifty years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn Infants give residence of mother)
State: Maryland County: Montgomery
City or town: R F D Brookville no
(If outside city or town limits, write RURAL and give nearest town)
Street No.: —
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME Malinda E. Brown

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Allen Bowie Brown
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1860 Feb 23.

8. AGE: Years	Months	Days	If less than one day
85	0	0	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Home

FATHER
12. Name: William Dwyer
13. Birthplace: Montgomery Co Md

MOTHER
14. Maiden name: Sarah Jane Coombs
15. Birthplace: Montgomery Co Md

16. Informant: Mrs Bertha V. Brown
Address: Brookville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 26 1945 (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: Montgomery Co Md

18. Funeral director: Roy W. Barber
Address: Laytonsville Md

19. 2/26/45 (Date rec'd by registrar) 19____ L D Beall Registrar Asst.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23 1945, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1942, to Feb 23 1945
and that I last saw h.. alive on Feb 23 1945

Immediate cause of death	DURATION
Coronary occlusion	15 hrs
Due to: Chronic myocarditis	
with hypertension	3 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Chas E Tumbleson M. D. or coroner
Address: Sandy Springs Md Date signed 2/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

01861

Reg. Dist. No. 716

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?: 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1001 Crawford

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Katherine Y. Buhrman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed.

6.(b) Name of husband or wife: Alfred G. Buhrman deceased

6.(c) If alive, give age: ..... years

7. Birth data of deceased (mo., day, yr.): Nov. 3, 1881

8. AGE: Years	Months	Days	If less than one day
63	3	9	..... hrs. ..... min.

9. Birthplace: Washington, District of Columbia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: John Young

13. Birthplace: Germany

MOTHER

14. Maiden name: Lavina Young

15. Birthplace: New York

16. Informant: Barbara B. Buhrman

Address: 1001 Crawford Dr. Rockville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/13/45 (month) (day) (year)

Cemetery or crematory: Glenwood Cem.

Location: Washington, D.C.

18. Funeral director: Wm. Reuben Humphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 2/13 19 45 (Date rec'd by registrar)

Wm E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/12/45 19 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2- 19 45 to Feb 12, 19 45

and that I last saw h[illegible] alive on Feb. 12, 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 days
Due to: Chronic Cardio-vascular	3 yrs.
Due to: disease (hypertensive)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. G. Bauersfeld M. D.

M. D. or other

Address: Bethesda, Md. Date signed: 2/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (190)

CERTIFICATE OF DEATH

01862

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital

How long in hospital or institution? 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. #1 - Emory Grove
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John W. Campbell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Widowed

6.(b) Name of husband or wife Annie Campbell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 4, 1873

8. AGE: Years	Months	Days	If less than one day
71	7	17	..... hrs. ..... min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER 12. Name John H. Campbell

FATHER 13. Birthplace

MOTHER 14. Maiden name Henrietta Brown

MOTHER 15. Birthplace

16. Informant Hospital records

Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb 24 1945 (month) (day) (year)

Cemetery or crematory Oak Grove M.E.

Location Mt Zion Md

18. Funeral director Roy W Barber

Address Laytonsville Md

19. Feb. 23 1945 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1945 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 1945 to Feb. 21 1945 and that I last saw him alive on Feb. 21 1945

Immediate cause of death	DURATION
Chronic Myocarditis & Chronic Nephritis	unknown
Due to	
Due to	
Other conditions Frozen feet	2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas E Tumblestone M. D. or other

Address Sandy Spring, Md. Date signed 2/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

(1863)

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2026 Gosnell st

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur Carlton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 10 1897

8. AGE:

Years	Months	Days	If less than one day
47	4	10	..... hrs. ..... min.

9. Birthplace N.o Hampshire (Laconia)
(Town, county, and state)

10. Usual occupation Retired army sergeant

11. Industry or business

FATHER

12. Name unknown

13. Birthplace "

MOTHER

14. Maiden name unknown

15. Birthplace

16. Informant Jos. A. Bennett

Address 2026 Gosnell st Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-22-45 (month) (day) (year)

Cemetery or crematory Wash. D.C. Arlington National

Location Arlington, Va.

18. Funeral director W. R. Tabler

Address 4247 - 9th St. N.W. Wash. D.C.

19. Feb. 20 19 45 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 19 45 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 ... to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
coronary occlusion	Unknown suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broccard M.D.
Dep. Med. Exam. M. D. or other

Address Gaithersburg Md Date signed 2-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 45-15 Gladmore Dr.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 45-15 Gladmore Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Pearl W. Caruso

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Henry H. Caruso

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 24 1913

8. AGE: Years: 31 Months: 5 Days: 13 If less than one day: ..... hrs. ..... min.

9. Birthplace: Gaithersburg md (Town, county, and state)

10. Usual occupation: grammar clerk

11. Industry or business: —

FATHER — 12. Name: Mack Walker

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Barbara C. Holland

MOTHER — 15. Birthplace: Md.

16. Informant: Grace Walker

Address: Gaithersburg md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Jan. 24 1946 (month) (day) (year)

Forest Oak Cedar Hill Cemetery

Cemetery or crematory

Location: Maryland, Gaithersburg

18. Funeral director: Wm Reuben Dumphrey

Address: 7557 Wis. Ave. Bethesda Md

19. 1/23 1946 Mr E Dolci

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: About Feb 12 1945 at Montgomery M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. post. Exam Case 19 ..... to ..... 19 .....

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Unknown	
Head found 2-27-45 in woods near Brandywine Md. Decapitated	
Due to by saving thru body of 4th cervical Vertebra	
Due to (homicide)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: homicide Date of about Feb 12, 45

Where did injury occur? Bethesda (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brochato M.D.

M. D. or other

Address: Gaithersburg md Date signed 1-23-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

01864

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 hrs. 44 min.
Hospital, institution, or street address where death occurred: Suburban Hospital
Bethesda 14, Maryland
How long in hospital or institution? Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: — County: —
City or town: —
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Infant Boy Caruso

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: —
6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): February 16, 1945
8. AGE: Years — Months — Days — If less than one day: 13 hrs. 44 min.
9. Birthplace: Bethesda, Maryland (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —
FATHER 12. Name: Ralph Henry Caruso
13. Birthplace: Canonsburg, Pennsylvania
MOTHER 14. Maiden name: Martha Elizabeth Flax
15. Birthplace: Danville, Virginia
16. Informant: (mother) Mrs. Ralph H. Caruso
Address: 4901 Rugby Ave., Bethesda, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/19/45 (month) (day) (year)
Cemetery or crematory: Rockville Union
Location: Rockville, Maryland.
18. Funeral director: Wm. Reuben Humphreys
Address: Bethesda, Maryland
19. 2/18 1945 (Date rec'd by registrar) Wm. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/19 1945 at 1:44 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/16 1945, to 2/19 1945 and that I last saw him alive on 2/16 1945

	DURATION
Immediate cause of death: Prematurity - 6 month baby	13 hr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Bruce F. Benjamin M.D.
M. D. or other
Address: Bethesda, Md. Date signed 2/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01865

Reg. Dist. No. 214

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 407 Brewster Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 407 Brewster Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jane Childs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	W	Widowed

6.(b) Name of husband or wife: William Childs

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feby 25, 1866

8. AGE: Years	Months	Days	If less than one day
78	11		..... hrs. ..... min.

9. Birthplace: Co. Kildare Ireland (Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER — 12. Name: mr. Kavanagh

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Jane Kavanagh

15. Birthplace: Ireland

16. Informant: Williams Childs

Address: 407 Brewster ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 8. 1945 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Washington D.C.

18. Funeral director: Albert J. Ashe

Address: 641-H St. N.E.

19. Feb. 6th 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 6 1945, at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29 1945, to Feby 5 1945

and that I last saw her alive on Feby 4 1945

Immediate cause of death	DURATION
Bronchial pneumonia	3 days
Due to	
Due to	
Other conditions: acute hypertension	several years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John N. Andrews M.D. M. D. or other

Address: 9601 Colesville Rd Silver Spring Md Date signed: 2-6-45

Evidence for change of age of deceased is shown on FILM No. G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

01866

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one month & 18 days

Hospital, Institution, or street address where death occurred:
U.S.Naval Hospital, Bethesda, Md.

How long in hospital or institution? one month & 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: S. C. County:

City or town: Central
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CHILDS, John Frank,

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Ethel N. Childs

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 24 Sept. ~~1922~~ 1892

8. AGE:	Years	Months	Days	If less than one day
	52	2	22	hrs. min.

9. Birthplace: Ga.
(Town, county, and state)

10. Usual occupation: Teaching 1921-1944

11. Industry or business: Pres. & Trea. Jr. College Central, S.C.

FATHER
12. Name: Bennie H. Childs
13. Birthplace: Ga.

MOTHER
14. Maiden name: Sally E. Nelms
15. Birthplace: Georgia (deceased)

16. Informant: wife: Mrs. Ethel N. Childs
Address: Central, S. C.

17. removal (Burial, cremation, or removal. Which?) Date thereof 2-17-45 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: W. W. Chambers
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 17 Feb. 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 Feb. 1945, at 10:42p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 Dec. 1944 to Feb. 16 1945 and that I last saw h... im alive on Feb. 16 1945

Immediate cause of death	DURATION
Tumor, Mediastinum	12 yrs
Malignant; Spindlecell sarcoma, ovoc.	
Due to Cerebral anoxemia during arrest of heart	
Due to asthenoperation for some minutes. Cardiac massage	
Other conditions revived heart action but cerebral damage had taken place.	

(Include pregnancy within 3 months of death)

Major findings of operation: Large Anterior mediastinal tumor. Date of op. 16 Feb 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Edward M. Kent

23. SIGNATURE: E. M. KENT, Lt.Comdr. (MC) USNR
M. D. or other

Address: U.S.N.H., Bethesda, Md. Date signed: 2-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

01867

Reg. Diat. No. 2-16

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 2 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Glen Echo
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Tulane Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Daniel Collins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife: Clara O'Neil
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5, 1861

8. AGE: Years	Months	Days	If less than one day
83	9	18	hrs. min.

9. Birthplace: Potomac, Md. (Town, county, and state)
10. Usual occupation: Watchman
11. Industry or business
FATHER 12. Name: Richard Collins
13. Birthplace: Md.
MOTHER 14. Maiden name: Sarah Houser
15. Birthplace: Md
16. Informant: Brother Tyler Collins
Address: Potomac, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/26/45 (month) (day) (year)
Cemetery or crematory: Potomac Cemetery
Location: Potomac, Md.
18. Funeral director: Wm Reuben Dempsey
Address: 7557 Wis. Ave. Bethesda, Md.
19. 2-24-45 (Date rec'd by registrar) 19 W. E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 23, 1945 at 7:47 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1944 to 19
and that I last saw h alive on Feb 23 1945

Immediate cause of death	DURATION
Coronary occlusion	2 1/2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. M. D. or other
Address: Dep. Med. Exam. Frederick, Md. Date signed 2-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

01868

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co

City or town: Clarksburg Md. (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montg,

City or town: Clarksburg Md, (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Eli Garrett Cooley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Effie Ann Cooley

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Sept 17th 1868

8. AGE: Years	Months	Days	If less than one day
1868 76	4	16	hrs. min.

9. Birthplace: Clarksburg Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Amos Cooley
13. Birthplace: Md,

MOTHER
14. Maiden name: Elizabeth Mitchell
15. Birthplace: Md,

16. Informant: Effie Ann Cooley
Address: Clarksburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/6/45 (month) (day) (year)

Cemetery or crematory: Clarksburg Cemetery

Location: Clarksburg Md

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md,

19. Feb 4 1945 (Date rec'd by registrar) Amada G Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 3rd 1945, at 4.35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1944, to Feb 2 1945 and that I last saw h[illegible] alive on Feb 2 1945

Immediate cause of death	DURATION
Sinus Tachycardia	
Due to: —	
Due to:	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W Perry Shurley my M. D. or other

Address: Gaithersburg Date signed Feb 3 1945.

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(I)

Evidence for change of age & birth date of deceased is shown on FILM No. G 94 MAY 14 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01869

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Mont.

City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred: 4827 Fairmont Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Monty

City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4827 Fairmont Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Arthur Dallenger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married.

6.(b) Name of husband or wife: Catherine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 21, 1863 1868

8. AGE: Years	Months	Days	If less than one day
76	-7-		..... hrs. ..... min.

9. Birthplace: England
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Benjamen Dallenger
13. Birthplace: England.

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown.

16. Informant: Emma Yarrington
Address: 4827 Fairfont Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/2/45 (month) (day) (year)

Cemetery or crematory: National Memorial Park Cemetery

Location: Lee Highway Va.

18. Funeral director: Wm Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda, Md

19. 2/2 (Date rec'd by registrar) 1945 Wm E. Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 1, 1945, at 12:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1942 to Feb 1945

and that I last saw h... alive on Jan 31 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 Hr.
Due to Arteriosclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 806 Rumsey Rd Date signed 2/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

01870

Reg. Dist. No. 213-

1. PLACE OF DEATH:
County Montgomery
City or town Rockville R.F.D.# (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville, R.F.D. #1 (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Davis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1874

8. AGE: Years 70 | Months 5 | Days 21 | If less than one day ... hrs. ... min.

9. Birthplace maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Konenor Davis
13. Birthplace Va.

MOTHER
14. Maiden name Rachel Murphy
15. Birthplace Howard Co. Md.

16. Informant Himothy Davis
Address Rockville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb 5 1945 (month) (day) (year)
Cemetery or crematory Norbeck
Location Norbeck, Md.

18. Funeral director Robert L. Snowden
Address 246 D. Wash. St Rockville

19. Feb 5 1945 (Date rec'd by registrar) Josephine D. Waters Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1945, at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept Med. Exam 19 to case 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Myocarditis	Died suddenly
Due to Chronic Cardio-renal disease	6 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchat M.D.
M. D. or other
Address Sept. Med. Exam Gaithersburg, Md. Date signed 2-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

01871

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months and 24 days
Hospital, institution, or street address where death occurred:
U.S.NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? 2 mons. 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2901 Army Navy Drive,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DAY, Paul (n), Slc SV USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Rommel Day
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 25 July 1914

8. AGE: Years	Months	Days	If less than one day
30	7	1	..... hrs. ..... min.

9. Birthplace: S.C.
(Town, county, and state)
10. Usual occupation:
11. Industry or business: Navy
FATHER 12. Name: Jacob Day
13. Birthplace: S.C.
MOTHER 14. Maiden name: Estell Hall
15. Birthplace: S.C.
16. Informant: Wife: Mrs. Rommel Day
Address: 2901 Army Navy Drive, Arlington, Va.
17. removal (Burial, cremation, or removal. Which?) Date thereof 2-16-45 (month) (day) (year)
Cemetery or crematory:
Location: West Columbia, S.C.
18. Funeral director: W.W. Chambers, Per J.B.Le
Address: 1400 Chapin St., N. W., Wash., D. C.
19. 2-16-45 (Date rec'd by registrar) 19.....
Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 Feb. 19 45, at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Nov. 19 44, to 15 Feb. 19 45
and that I last saw him alive on Feb. 15 19 45

	DURATION
Immediate cause of death: lobar Pneumonia	3 days
Due to: acute Mycogenous Leukemia	4 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: none done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... injured at work?

23. SIGNATURE: W. T. Gibb Jr. W. T. GIBB, Jr. Comdr. (MC) USNR
M. D. or other
Address: US N.H., Bethesda, Md. Date signed: 2-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM G94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

01872

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Metropolitan Grove
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Metropolitan Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Henry Harsey Jr.

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Nora P. Harsey
6.(c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): December 10, 1867

8. AGE: Years: 78 77 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Charles County, Md
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: John Henry Harsey
13. Birthplace: Charles County, Md

MOTHER
14. Maiden name: Julia Chase
15. Birthplace: Charles County, Md

16. Informant: Nora P. Harsey (Wife)
Address: Metropolitan Grove, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 16 1945 (month) (day) (year)
Cemetery or crematory: Emery Grove Cem
Location: Emery Grove, Md.

18. Funeral director: Robert L. Snowden
Address: 246 N. Wash. St. Rockville, Md.

19. Feb 14 1945 (Date rec'd by registrar) Alveda L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 13 1945 at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6 1945 to Feb 12 1945
and that I last saw him alive on Feb 12 1945

	DURATION
Immediate cause of death: Bronchopneumonia	
Due to: Pneumonitis	
Due to:	
Other conditions: Valvular disease of Heart	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Gaithersburg Date signed: Feb 14 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-1)

CERTIFICATE OF DEATH

01873

Reg. Dist. No. 191 247

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Brookeville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Glenwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Knollwood

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: George Leonard Dwyer

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Nettie Dwyer

8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 4, 1871

8. AGE: Years	Months	Days	If less than one day
74	0	9	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Labor.

11. Industry or business

FATHER — 12. Name: Wm E. Dwyer.

13. Birthplace: Md.

MOTHER — 14. Maiden name: Debra Musgrove

15. Birthplace: Md

16. Informant: Mrs G.L. Dwyer

Address: Glenwood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-16-45 (month) (day) (year)

Cemetery or crematory: Providence

Location: Glenelg Md.

18. Funeral director: J.C. Higinbotham

Address: Ellicott City Md

19. Feb. 16, 1945 (Date rec'd by registrar) John B. Laughran Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 13 1945, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 13 1945 to Feb 13 1945 and that I last saw him alive on Feb 13 1945

Immediate cause of death	DURATION
Carcinomatosis of chest	unknown
Due to: Carcinoma of throat	2 years
Due to:	
Other conditions: no	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.:

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: no Injured at work? no

23. SIGNATURE: Chas E. Tumbleson M. D.

Address: Sandy Spring Md. Date signed: 2/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

1874

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery Co.

City or town Bethesda - Maryland -
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Suburban Hospital.

How long in hospital or institution? 6 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Monty

City or town Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6402 Beechwood Drive.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
(Mrs.) Gertrude Eastman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	widow

6.(b) Name of husband or wife Frank W. Eastman
deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 5 - 1862

8. AGE:

Years	Months	Days	If less than one day
82	4	7	..... hrs. ..... min.

9. Birthplace Arlington - Mass.
(Town, county, and state)

10. Usual occupation H.W.

11. Industry or business

FATHER
12. Name Ed. Chapman
13. Birthplace Conn.

MOTHER
14. Maiden name ? Field
15. Birthplace Mass.

16. Informant Mrs. F.C. Meier - daughter
Address 6402 Beachwood Drive. C.C. Md.

17. Shipment Date thereof 5/31/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Framingham, Mass.

Location Framingham, Mass.

18. Funeral director Wm Reuben Humphreys

Address 7557 Wis. Ave. Bethesda, Md.

19. 6/31 1945 Wm E Johns Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1945, at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1944, to Feb. 11 1945
and that I last saw h[illegible] alive on Feb. 11 1945

Immediate cause of death	DURATION
Peritonitis	3 days
Due to Cholelithiasis	unk
Due to Seepage from gall bladder	1 week
Due to gaping old Pelvic adhesions	2 yrs.
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Peritonitis, acute exudative cholelithiasis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C.B. Wadsworth M.D. M. D. or other

Address 943 Bonifant St. Date signed 2/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-6)

CERTIFICATE OF DEATH

01675 522

Reg. Dist. No. 2 16

1. PLACE OF DEATH: County Montgomery; City or town Cabin John Gardens (If outside city or town limits, write RURAL NEAR and give town); Street address, hospital, or institution: #25 Ericsson Road; Stay in hospital or inst. (yrs., or mos., or days) ——; Stay in this community (yrs., or mos., or days) 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State —— County ——
City or town —— Ward No. ——
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ——
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ——

3. (a) FULL NAME Garry James Eanes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6 (b) Name of husband or wife (child)

6(c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) October 28—1944.

8. AGE: Years —— Months 3 Days 6 If less than one day —— hrs. —— min.

9. Birthplace #25-Ericsson Rd. Cabin John Gardens Cabin John, Md. (Town, county, and state)

10. Usual occupation Child

11. Industry or business ——

FATHER
12. Name ~~Garry~~ Lee Edward Eanes
13. Birthplace Virginia

MOTHER
14. Maiden name Frances Hodges
15. Birthplace Virginia

16. Informant Frances Eanes
Address #25-Ericsson Rd. Cabin John Gardens Cabin John, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5 1945 (month) (day) (year)
Cemetery or crematory National Memorial Park
Location Falls Church, Va.

18. Funeral director W W Chambers Co
Address 302 — M St NW

19. 2-3-45 (Date rec'd by registrar) 19—— ME Jobes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3rd 1945, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2 1945, to Feb. 3 1945, and that I last saw him alive on Feb. 2 1945.

Immediate cause of death	DURATION
Oedema of the glottis.	a few hours.
Due to Septic sore throat	2 days
Due to Exposure	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ——
Of autopsy ——

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide —— Date of ——
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ——
Means of injury —— Injured at work?

23. SIGNATURE Wheeler D. Huff, M.D. M. D. or other
Address Bethesda, Md. Date signed Feb. 3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

01876

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1628 N. 16th St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: EDIE, Ann

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Capt. J. R. Edie USN Ret.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1884

8. AGE: Years	Months	Days	If less than one day
61	0	2	hrs. min.

9. Birthplace: Tenn (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: husband: Capt. J. R. Edie, Ret.
Address: 1628 16th St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2-17-45 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

16. Funeral director: Joseph Gawler R.B.
Address: 1750 Penn., Ave., N. W., Wash., D.C.

19. 15 Feb. 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 15 19 45 at 6.10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 19 45 to Feb. 15 19 45 and that I last saw h. alive on Feb. 14 19 45

	DURATION
Immediate cause of death: Cerebral Hemorrhage	? years
Due to: a. Right Hemiplegia (Recurrent)	1 week
Due to: and Diffuse Glial Proliferation	4 days
Due to: Hypertension	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gordon R. Lamb M. D. or other
Address: Nat. Naval Med. Center Date signed: Feb. 15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (W)

01877

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montg Co

City or town: Silverspring, Md, (Rural)

(If outside city or town limits, write RURAL and give nearest town)

1 Yr 2Da

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montg Co

City or town: Silverspring, (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9509 Riley Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Roberta Garrett Esworthy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Wid Ow

6.(b) Name of husband or wife: Frank Esworthy

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 14th 1859

8. AGE: Years	Months	Days	If less than one day
1859 85	4	0	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: " "

FATHER 12. Name: Samuel Thrift

13. Birthplace: Md,

MOTHER 14. Maiden name: Ellen Hawkins

15. Birthplace: Md,

16. Informant: Eva Byrnes

Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/17/45 (month) (day) (year)

Cemetery or crematory: Darnestown Cemetery

Location: Darnstown Md,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md,

19. Feb 14 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14th 1945 at 12.25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 31 1944 to Feb 14 1945 and that I last saw h...ex alive on Feb 13 1945

Immediate cause of death	DURATION
Congestive Heart Failure	3 days.
Due to Cardiovascular Renal Disease.	10 yrs.
Due to Diabetes Mellitus	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harold Haugen, M.D. M. D. or other

Address: Mayflower Hotel Date signed 2/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

01878

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Wilson Lane near River Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Agnes Evans

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: William

6.(c) If alive, give age ..... years

7. Birth date of deceased (mn., day, yr.): Sept-11, 1883

8. AGE: Years	Months	Days	If less than one day
61	5	15	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
12. Name of father: Frazier
13. Birthplace of father: Virginia
14. Maiden name of mother: Clark
15. Birthplace of mother: Virginia
16. Informant: self
Address

17. (Burial, cremation, or removal, which?) Burial Date thereof 3-1-45 (month) (day) (year)
Cemetery or crematory: Potomac
Location: Potomac, Md.
18. Funeral director: Wm Reuben Dempsey
Address: Bethesda, Md.

19. 3-1-45 (Date rec'd by registrar) 19 ..... W E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 26, 1945 at 7:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24 1945, to Feb 26, 1945 and that I last saw h.. alive on Feb 26, 1945

Immediate cause of death	DURATION
Acute Septic Hepatitis	
Peritonitis & mesenteritis	
Due to Diverticulosis	
Protracted alcoholism	
Due to Perforated Hernia	20 yrs.
Other conditions Pulmonary congestion	

(Include pregnancy within 3 months of death)

Major findings of operations: Incarcerated Hernia, Jejunum
Date of op.
Autopsy results: C.P.C. Lungs, Mes. Thrombosis & Peritonitis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) ..... (County) ..... (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Carey Logan, M.D. M. D. or other
Address: 1801 Eye St. N.W. Dc. Date signed 3.1.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52

CERTIFICATE OF DEATH

01879

Reg. Diat. No. 223-

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Wash. D.C. County

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1206 Kennedy St.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Margaret Frederick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William Arthur Frederick 6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 12 1884

8. AGE: Years	Months	Days	If less than one day
60	7	12	...hrs. ...min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name Michael Whalen
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Harvey
15. Birthplace Ireland

16. Informant Admission record on chart
Address

17. ...
(Burial, cremation, or removal. Which?) Date thereof... (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director The S. N. Hines Co
Address 2901-14-st N.W. Wash. D.C.

19. 2-25-45 (Date rec'd by registrar) 18... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 19 45 at 10 50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8 19 45 to Feb. 24 19 45 and that I last saw h.. alive on Feb. 23 19 45

Immediate cause of death	DURATION
Carcinoma of Bladder	
Due to: with Metastases to	
Surrounding tissues	6 years
Due to:	
Other conditions Pyelonephritis —	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results As above —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE John H. Brownlee M.D.
M. D. or other

Address Takoma Park — Date signed 2/24/45

J. W. Hadley Deputy Registrar

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01884

Reg. Dist. No. 213.

1. PLACE OF DEATH:
County Montgomery
City or town Redland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, institution, or street address where death occurred:
Redland, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Monty
City or town Redland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Redland, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henrietta Gardiner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1861

8. AGE: Years 84 | Months 7 | Days 2 | If less than one day ... hrs. ... min.

9. Birthplace Frederick Co.
(Town, county, and state)

10. Usual occupation Retired Nurse

11. Industry or business

FATHER
12. Name William Gardiner
13. Birthplace unknown

MOTHER
14. Maiden name Ann Greene
15. Birthplace Hartford Co. Md.

16. Informant Melvin S. Penn
Address Nephew, Redland, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 2/8/45 (month) (day) (year)
Cemetery or crematory St. Rose's Clappers Cemetery
Location Maryland

18. Funeral director Leo Reuben Dunphrey
Address Rockville, Md.

19. 2/6/45 (Date rec'd by registrar) Josephine D. Hatton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 19 45 at 10 o'clock A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 Feb. 5 19 to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death Coronary occlusion	Some hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart M.D.
M. D. or other
Address Gaithersburg, Md. Date signed 2-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth is shown on FILM C 21 MAY 11 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01881

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery Co.

City or town Bethesda [illegible] Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital.

How long in hospital or institution? 2 wks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington - md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 41 DuPont Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war None.

3.(a) FULL NAME (Mrs) Evelyn L. Gooding

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	married.

6.(b) Name of husband or wife Charles B. Gooding

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct - 10 - 1882

8. AGE: Years	Months	Days	If less than one day
62	4	8	..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER
12. Name Joseph Fleming
13. Birthplace Richmond, Va.

MOTHER
14. Maiden name Josephine Padgett
15. Birthplace Richmond, Va.

16. Informant Charles B. Gooding.
Address 41 DuPont Ave. Kensington

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 20 - 45 (month) (day) (year)

Cemetery or crematory Glenwood.

Location Washington. D.C.

18. Funeral director Ward E. Pumphrey.

Address 8434 Ga Ave - Silver Spring.

19. Feb. 20 19 45 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 19 45 at 9 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1945, to Feb. 15 1945 and that I last saw h[illegible] alive on Feb. 15 1945

Immediate cause of death	DURATION
Coronary Thrombosis	10 days
Due to	
Due to	
Other conditions Hypertension Heart disease	—

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiation of clinical diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Marion Bamford M.D.
M. D. or other

Address Silver Spring, Md. Date signed 3/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

01882

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred:

U.S.Naval Hospital, Bethesda, Md.

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Army and Navy Club

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: GREEN, Lucien Byron, Lt.Comdr. USN Ret.Inactive

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6 Jan 1889

8. AGE: Years	Months	Days	If less than one day
56	1	20	hrs. min.

9. Birthplace: Wis.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER — 12. Name: Albert E. Green

13. Birthplace: Wis. (deceased)

MOTHER — 14. Maiden name: Olive Austin

15. Birthplace: Ill. (deceased)

16. Informant: son: Sgt. Lucien B. GREEN

Address: Box X, Gambou, Canel Zone

17. burial (Burial, cremation, or removal. Which?) Date thereof: 2-28-45 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: S. H. HINES W. Brown.

Address: 2901 14th St., N. W., Wash., D.C.

19. Feb. 26 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-26 1945, at 0115 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Feb 1945, to 26 Feb 1945 and that I last saw him alive on 25 Feb 1945

Immediate cause of death	DURATION
Hemorrhage from esophageal varicosities	
Due to: Atrophic Cirrhosis of the liver	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: Cirrhosis of liver with esophageal varicosities

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Combs Lieut MC USNR M. D. or other

Address: US Naval Hospital, Bethesda Date signed: 2/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

526

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (62)

CERTIFICATE OF DEATH

01883

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
608 Pickwick Lane

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 608 Pickwick Lane
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
Anna Augusta Heitmuller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Albert Heitmuller

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 18 September 1859

8. AGE:

Years	Months	Days	If less than one day
85	4	16	hrs. min.

9. Birthplace Reusendorf, Germany
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Housewife

FATHER
12. Name August Marshalk
13. Birthplace Germany

MOTHER
14. Maiden name Christine ?
15. Birthplace Germany

16. Informant Anita Louise Foster

Address 608 Pickwick Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-4-45 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director L. H. Hines Co

Address Wash DC.

19. 2-4-45 (Date rec'd by registrar) 19 N E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 February 1945, 19, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated. That I attended deceased from Staff of Walter Reed Hospital
21 June 1943, to 4 February 1945,
and that I last saw her alive on 2 February 1945.

	DURATION
Immediate cause of death Pulmonary embolism	Unknown
Due to Fracture, right hip, 27 October 1944.	3½ mos
Due to Accidental fall. Patient slipped and fell in her bedroom. Cause?	
Other conditions Arteriosclerosis, generalized with hypertension. (Include pregnancy within 3 months of death)	Unknown

Major findings:
Of operations no
Of autopsy no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide Accident. Date of
Where did injury occur? Chevy Chase, (City or town) Montgomery (County) Maryland. (State)
injured at home, farm, industry, public place (where?)
Means of injury Accidental fall, injured at work?

23. SIGNATURE W. Nalls
W. L. Nalls, Lt. Colonel, M. C. M. D. or other
Address Date signed 5 Feb 1945

WALTER REED GENERAL HOSPITAL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01884

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4818 South 30th Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HENNIGAR, William Everett, Captain USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Gladys Hennigar
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 17 May 1901

8. AGE: Years	Months	Days	If less than one day
43	9	18	hrs. min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: Navy
11. Industry or business
FATHER 12. Name: William A. Hennigar
13. Birthplace: N.Y.
MOTHER 14. Maiden name: Alice Smith
15. Birthplace: N.Y.
16. Informant: wife: Mrs. Gladys Hennigar
Address: 4818 South 30th St., Arlington, Va.
17. burial (Burial, cremation, or removal. Which?) Date thereof 22 Feb. 45 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.
18. Funeral director: W. W. CHAMBERS Per DB, Jr.
Address: 1400 Chapin St., N. W., Wash., D. C.
19. 20 Feb. 45 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 Feb. 45, at 6:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Feb. 45 to 19 Feb. 45
and that I last saw h... im alive on 19 Feb. 45

Immediate cause of death	DURATION
Toxemia Bacterial	72 hrs
Due to Pneumonia	
Due to Diverticulitis Intestinal	7 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: 1) Diverticulitis Sigmoid
Obstruction Intestinal Date of op. 2-16-45, 2-19-45
Autopsy results: Bilateral Broncho Pneumonia, Diverticulitis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Warren Sagan Comdr (MC) USNR M. D. or other
Address: US NAVAL HOSP., Bethesda, Md. Date signed 2-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

01885

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 35 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Friendship Heights, Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. River Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Edward Hill

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1898?

8. AGE: Years	Months	Days	If less than one day
46?	4	17	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name John Hill
13. Birthplace Maryland

MOTHER
14. Maiden name Donald
15. Birthplace Maryland

16. Informant
Address

17. Removal Date thereof 2-20-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
Location

18. Funeral director J. H. Love
Address 2426 - 24th St. N.W. D.C.

19. 2-25-45 W. E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1945 at 720 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Bronchopneumonia, acute Myocarditis, Embolus (Left upper)	
Due to Acute Rheumatic Endocarditis	
Due to 1st, 2nd & 3rd degree burns of face & both forearms & hands & upper chest	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results 1st 2nd & 3rd degree burns of face & both forearms & hands & upper chest
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of Jan 15-1945
Where did injury occur? Glencoe (490 Newport Ave) Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Industry
Means of injury Burns Injured at work? Yes

23. SIGNATURE J. H. Binet M. D. or other
Address Army Pathologist Date signed 2/19/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01886

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, institution, or~~ street address where death occurred:

7611 Eastern Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montg.

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7611 Eastern Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Ruby S. Howell

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband ~~or wife~~: Henry C. Howell

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1889

8. AGE: Years	Months	Days	If less than one day
55	5	0	____ hrs. ____ min.

9. Birthplace: Mt. Forest, Conn.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Robert Scott

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Mary Ann Reed

MOTHER — 15. Birthplace: Canada

16. Informant: Henry C. Howell

Address: 7611 Eastern Ave., Takoma Park, Md.

17. Shipment & burial — Date thereof: Feb. 10, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery ~~or crematory~~: Mt. Pleasant

Location: Newark, New Jersey

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. Feb 9th 1945 — Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 8 1945, at 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam 19__ to date 19__

and that I last saw h__ alive on ____ 19__

	DURATION
Immediate cause of death:	
Coronary occlusion	short sudden
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Frank J. Bouchart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed 2-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

01887

CERTIFICATE OF DEATH

Reg. Diat. No. 716

1. PLACE OF DEATH:
County Monty.
City or town Kensington Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Years -
Hospital, Institution, or street address where death occurred:
137 Garrett Park Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Monty
City or town Kensington Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 137 Garrett Park Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Michael Wade Hughes

3. (b) Social Security Number 225-05-4087

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married.

6.(b) Name of husband or wife Bertha.
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 20, 1876

8. AGE: Years	Months	Days	If less than one day
68	7	0	hrs. min.

9. Birthplace Poolesville, Md. (Town, county, and state)
10. Usual occupation Laboratory Technician, Nail Instr.
11. Industry or business

FATHER
12. Name William D. Hughes
13. Birthplace Monty. Co. Md.

MOTHER
14. Maiden name Elizabeth Connelly
15. Birthplace Monty. Co. Md.

16. Informant Mrs. Bertha Hughes
Address 137 Garrett Park Rd. Kens. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/23/45 (month) (day) (year)
Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg Maryland
18. Funeral director Wm Reuben Dumphrey
Address 7557 Wis. Ave. Bethesda, Md.
19. 2/22 19 45 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1945, at 6:45 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam to Case 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchart M.D.
Dep. Med. Exam. M. D. or other
Address Gaithersburg Md Date signed 2-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

01888

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 507 CARROLL AVE.

How long in hospital or institution? 4 YRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: MONTGOMERY

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

Street No. 507 CARROLL AVE.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: JAMES ALBERT JESTER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed.

6.(b) Name of husband or wife: Susan Jester.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 2, 1856

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
88	2	15.		

9. Birthplace: Marshall County, Ind.

(Town, county, and state)

10. Usual occupation: Retired Builder

11. Industry or business

FATHER — 12. Name: Calvert Jester.

13. Birthplace: Ind.

MOTHER — 14. Maiden name:

15. Birthplace

16. Informant: Emmet Jester

Address: 508 Carroll Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 20, 1945. (month) (day) (year)

Cemetery or crematory

Location: South Bend, Indiana.

18. Funeral director: Arthur Sellers

Address: 234 Carroll St. N.W., Takoma

19. Feb 17 1945 (Date rec'd by registrar) J. Fletcher Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 17, 1945; at 1 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 8, 1941 to Feb. 17, 1945; and that I last saw h. alive on Feb. 17, 1945.

Immediate cause of death	DURATION
Congestive Heart Failure	2 days
Due to: Arterio-sclerosis	Indefinite
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. B. Fletcher, M.D. (M. D. or other)

Address: 6911 5th St. N.W. Date signed: Feb. 17/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50) X

01889

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney, rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
Street No. Brookville Rd - nw Olney Dun.
(If rural, give LOCATION)
2.(a) If veteran, name war: none.

3. (a) FULL NAME Elizabeth Ogle Johnson

3. (b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	WIDOWED.

6.(b) Name of husband ~~or wife~~: ROBERT S.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): APR - 17 - 1868

8. AGE: Years	Months	Days	If less than one day
76	10	2	hrs. min.

9. Birthplace: WASH. DC.
(Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business

FATHER
12. Name: REZIN H. OGLE
13. Birthplace: WASH. DC

MOTHER
14. Maiden name: MARGARET WELLS
15. Birthplace: OHIO

18. Informant: MR AMBROSE DURKIN
Address: PORTNER APTS - WASH DC.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: FEB 22 45. (month) (day) (year)
Cemetery or crematory: GEO. WASH MEM'L
Location: RIGGS ROAD - PR. GEO'S CO.

18. Funeral director: WARNER E PUMPHREY
Address: 8431 Ga Ave - Silver Spring, Md

19. Feb. 20 19 45 Josephine M Schaffer
(Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19 1945, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944 to Feb. 19 1945 and that I last saw h alive on February 18 1945.

Immediate cause of death	DURATION
Carcinoma of Left breast	
with generalized metastasis - Sympt.	
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wm A. Leatherwood, M.D.
M. D. or other
Address: Rockville, Md. Date signed: 2/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01890

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months 8 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 months 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1926 21st Place, S.E.,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: KIRSCH, Gladys

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: John Kirsch, CGM USN
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 6, 1900

8. AGE: Years	Months	Days	If less than one day
45	1	3	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Daniel Gibbons
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mepina Stansberry
15. Birthplace: Maryland

18. Informant: husband: Mr. John Kirsch,
Address: 1926 21st Place., S. E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2-12-45 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Washington, D. C.
18. Funeral director: Lee Funeral Home R.B.C.
Address: 4th & Mass., Ave., N.E., Wash., D.C.

19. 9 Feb. 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 9th 1945, at 7.50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 31st 1944 to Feb. 9th 1945 and that I last saw her alive on Feb. 8th 1945

Immediate cause of death	DURATION
Hypertensive Heart Disease with Congestive Failure	10 years
Due to	
Due to	
Other conditions: Possible Malignancy of Left Breast.	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gordon R. Lamb M. D. or other
Address: U.S.N.H. Bethesda Date signed: Feb. 9 '45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

01891

CERTIFICATE OF DEATH

Reg. Dist. No. 212.

1. PLACE OF DEATH:
County: Montgomery
City or town: Gaithersburg Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 yrs.
Hospital, Institution, or street address where death occurred:
Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty.
City or town: Poolesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Carrie Davila Kohlhaas

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Harry Kohlhaas. 8.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1880

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
64	4	0		

9. Birthplace: Rockville, Monty. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Housekeeping
FATHER 12. Name: John Beard
13. Birthplace: Unknown
MOTHER 14. Maiden name: Lavinia Selby
15. Birthplace: Unknown
16. Informant: Mrs. Charles E. Kohlhaas.
Address: Poolesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 21, 1945 (month) (day) (year)
Cemetery or crematory: Monocacy Cemetery
Location: Beallsville, Md.
18. Funeral director: Mrs B. Hilton
Address: Barnesville, Md.
19. Feb. 19 19 45. Charles E. Kohlhaas
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 19 — 1945, at 7 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17 — 1945, to Feb. 19 — 1945 and that I last saw her alive on Feb. 19 — 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B. D. White, M.D. M. D. or other
Address: Poolesville, Md. Date signed: 2/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-M)

CERTIFICATE OF DEATH

01892

Reg. Dist. No. 716

1. PLACE OF DEATH:

County: Monty

City or town: Bethesda (outside)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days -

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1445 Otis Pl. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Martin Kroot

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married.

6.(b) Name of husband or wife: Ruth

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 16, 1911

8. AGE: Years	Months	Days	If less than one day
33	8	5	hrs. mio.

9. Birthplace: St. Louis, Mo. (Town, county, and state)

10. Usual occupation: Economist

11. Industry or business

FATHER

12. Name: Max Kroot

13. Birthplace: St. Louis, Mo.

MOTHER

14. Maiden name: Vera S. Rieter

15. Birthplace: St. Louis, Mo.

16. Informant: Emile Despres -

Address

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 2/24/45 (month) (day) (year)

Cemetery or crematory: Houston, Texas.

Location: Texas -

18. Funeral director: Wm Reuben Dumphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 2-24-45 (Date rec'd by registrar) 19 WE Jones, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 21, 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. Case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia due to carbon monoxide gas	Instant
Due to poising (suicide)	
Due to had been attending from ailment to year	
Other conditions	

(Ioclode pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followiog:

Accident, suicide, or homicide suicide Date of 2-22-45

Where did injury occur? (City or town) (Coonty) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brockett M.D. M. D. or other

Address: Gaithersburg Md. Date signed 2-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01893

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred: Grant Tour
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 101 S. Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Edith Stonestreet Lamar

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband ~~or wife~~: Bruce H. Lamar
8.(c) If alive, give age: ... years
7. Birth date of deceased (mo., day, yr.): June 20, 1871.

8. AGE:

Years	Months	Days	If less than one day
73	5	14	— hrs. — min.

9. Birthplace: Rockville, Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home

FATHER
12. Name: Edward E. Stonestreet
13. Birthplace: Monty. Co., Md.

MOTHER
14. Maiden name: Martha Rebecca Barry
15. Birthplace: Maryland

16. Informant: Mrs. Lucile L. Bryant Delaughter
Address: Lynchburg, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 6, 1945 (month) (day) (year)
Cemetery ~~or crematory~~: Rockville Union
Location: Rockville, Md.

18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. Feb. 5 1945 (Date rec'd by registrar) Josephine D. Hutton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 1945 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1928 19... to Feb. 4 1945; and that I last saw him alive on Feb. 4 1945.

	DURATION
Immediate cause of death: Acute coronary failure	attack 1 month
Due to: Myocarditis, Chronic	1 year.
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op. ...
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Wm. A. Faulkner, M.D. (M. D. or other)
Address: Rockville, Md. Date signed: 2/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

01894

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban
How long in hospital or institution? 1 hour 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Mont
City or town Boyds, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Edward Wawson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1862

8. AGE: Years	Months	Days	If less than one day
82		3	hrs. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation Farm hand
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden name Unknown
15. Birthplace
16. Informant
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 26 1945 (month) (day) (year)
Cemetery or crematory Linden Park Cemetery
Location Rockville, Md.
18. Funeral director Robert L. Snowden
Address 246 N. Wash. St. Rockville, Md.
19. 2-26-45 (Date rec'd by registrar) W E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1945, at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 19 Med. Exam to Case 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute myocarditis	1½ hrs.
Due to Chronic valvular heart disease	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brockett M. D.
Dept. Med. Exam M. D. or other
Address Gaithersburg, Md. Date signed 2-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on FILM No G 9 4 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

01895

Reg. Dist. No. 212

1. PLACE OF DEATH.

County Montgomery

City or town Barnesville not RFD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Barnesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Catherine Rebecca Long

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Claude Edgar Long

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ~~85~~ April 2 - 1860 1859

8. AGE: Years	Months	Days	If less than one day
85	10	23	..... hrs. ..... min.

9. Birthplace Lowettsville Va Loudon Co (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Farm

FATHER 12. Name William McCoy

13. Birthplace Loudon County Va

MOTHER 14. Maiden name Elizabeth Unknown

15. Birthplace Unknown

16. Informant Claude Edgar Long

Address Barnesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 28 1945 (month) (day) (year)

Cemetery or crematory Beallsville

Location Montgomery Co Md

18. Funeral director Roy W. Barber

Address Laytonsville Md

19. Feb. 27 1945 (Date rec'd by registrar) Mrs. C. C. Helton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1945 at 10 25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/10 1944 to 2/25 1945 and that I last saw her alive on 2/23 1945

Immediate cause of death	DURATION
Arteriosclerosis &	
Cardio-vascular-Renal Disease	10 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Byron D. White M.D. M. D. or other

Address Poolesville, Md Date signed 2/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01893

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Colesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs.
Hospital, institution, or street address where death occurred:
Colesville, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty. Co.
City or town: Colesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Colesville, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Edward Lechlider, Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife: Mary Elizabeth
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 29, 1881

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace: Baltimore, Maryland.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Charles E. Lechlider
13. Birthplace: Maryland
MOTHER 14. Maiden name: Amelia Johnson
15. Birthplace: Maryland.
16. Informant: Mrs. Mary Elizabeth Lechlider
Address: Colesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/11/45 (month) (day) (year)
Cemetery or crematory: Colesville Cemetery
Location: Colesville, Maryland
18. Funeral director: Wm Reuben Pumphrey
Address: 7557 Wis. Ave. Bethesda, Md.
19. Feb. 10 1945 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 9, 1945, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 16, 1939, to 2-9, 1945
and that I last saw h... alive on 2-9-45, 19...

Immediate cause of death	DURATION
Coronary Thrombosis	20 Min
Due to Recurrent attacks of Coronary Thrombosis. Due Arteriosclerosis	5 Yrs.
Due to Heart Disease	
Other conditions (3) Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Kenneth Laughlin M.D.
M. D. or other
Address: Suburban Bank Bldg Silver Spring Md. Date signed 2-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-6)

2431

01897

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4626 Rosedale Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs- Goldie Lee

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Luther Lee

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 14, 1892

8. AGE:

Years	Months	Days	If less than one day
52	11	23	..... hrs. ..... min.

9. Birthplace: Catharine, Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Enas Eaton

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Alvika Ayers

MOTHER — 15. Birthplace: Virginia

16. Informant: Mrs. Margaret Lee Benson

Address: Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/9/45 (month) (day) (year)

Cemetery or crematory: Upperville, Va. Cem

Location: Upperville Va.

18. Funeral director: Chas Reuben Dunphrey

Address: 7557 Wis. Ave. Bethesda

19. 2/8 1945 Thos E. Johns Md. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6, 1945, at 8 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 23 1945 to Feb. 6, 1945

and that I last saw h.. alive on Feb. 6, 1945

Immediate cause of death	DURATION
Intestinal obstruction	14 days
Due to: Adhesions from previous operation. Not due to cancer. Rec'd P.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: E. G. Bauersfeld M.D. M. D. or other

Address: Bethesda, Md Date signed 2/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01898

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3months & 20 days
Hospital, institution, or street address where death occurred:
US NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? 3 months & 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County:
City or town: Pittsburgh
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1100 Linden Place
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LOEFFLER, Vincent Aloysius, Ensign C-V(S) USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Fern Loeffler
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 17 Nov. 1914

8. AGE: Years	Months	Days	If less than one day
30	3	10	hrs. min.

9. Birthplace: Pa. (Town, county, and state)
10. Usual occupation:
11. Industry or business: Navy
FATHER 12. Name: George Loeffler
13. Birthplace: Germany (deceased)
MOTHER 14. Maiden name: Louise Naab
15. Birthplace: Germany
16. Informant: Wife: Mrs. Fern Loeffler
Address: 1100 Linden Place, Pittsburgh, Pa.
17. removal (Burial, cremation, or removal. Which?) Date thereof 2-27-45 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Pittsburgh, Pa.
16. Funeral director: W. W. CHAMBERS, Inc.
Address: 1400 Chapin St. N. W., Wash., D.C.
19. 2-27- 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 Feb. 1945 at 0955 a.m.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 7 1944 to 27 Feb. 1945 and that I last saw him alive on 27 Feb. 1945

Immediate cause of death	DURATION
(a) Respiratory paralysis	2
Due to: Brain tumor	3
Due to: Malignant glioma	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Malignant glioma brain tumor Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. B. Sheean M. D. or other
Address: USNH Bethesda Md. Date signed 2/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. G94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01899

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: Cabin John, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, institution, or street address where death occurred: Mc Arthur Blvd. & Tocks Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Monty.
City or town: Cabin John, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mc Arthur Blvd., Tocks Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas William Lynch

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Dora V.
6.(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): June 28, 1885 1875
8. AGE: Years: 69 Months: Days: If less than one day: hrs. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Martin Lynch
13. Birthplace: Monty. Co.
MOTHER 14. Maiden name: Susie Davis
15. Birthplace: Monty. Co.
16. Informant: wife
Address: Same
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/10/45 (month) (day) (year)
Cemetery or crematory: Rock Creek Cem.
Location: Washington, D. C.
18. Funeral director: Wm A. Reuben Dumphrey
Address: 7557 Wis. Ave. Bethesda, Md.
19. 2/8 (Date rec'd by registrar) 19 45 Wm E. Johnson Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 7, 1945 at 7 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 12, 1945 to Feb. 7, 1945
and that I last saw him alive on Feb. 7, 1945

	DURATION
Immediate cause of death: Coronary occlusion	3 wks
Due to: Chr. Cardio-vascular disease	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. G. Bamfield, M. D.
M. D. or other
Address: Bethesda, Md. Date signed: 2/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hours

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 906 S. Oak Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Hena Markowitz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Jewish	married

6.(b) Name of husband or wife: Samuel Markowitz

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 26, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	2	hrs. min.

9. Birthplace: Kishaed, Russia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: JACOB KAUFSITY

13. Birthplace: Russia (information not available)

MOTHER — 14. Maiden name: YACKUD

15. Birthplace: Russia

16. Informant: Washington Sanitarium and Hospital Records

Address: Takoma Park, Maryland.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar 1 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington DC

18. Funeral director: B Damsansky & Son

Address: 350 F - 14 St NW

19. March 1 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/28/ 19 45, at 9 32 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1945 to 2/28/ 19 45 and that I last saw h alive on Feb 28 19 45

	DURATION
Immediate cause of death: Hypertension and Coronary Disease with Angina Pectoris	6 years
Due to: Senility	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: 0

Date of op.:

Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically. 0

22. VIOLENCE: If death was due to external causes, fill in the following: 0

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas M. Wolfson, M.D.

M. D. or other

Address: 500 Edmond St N.W. Date signed: 2/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM No. G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01901

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Haiti

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Annie B Martin

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	English	Married

6.(b) Name of husband ~~or wife~~: Wm Martin

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): August 30 1874

8. AGE: Years	Months	Days	If less than one day
70 74			...hrs. ...min.

9. Birthplace: London, England (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER 12. Name: John Bailey

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Annie

MOTHER 15. Birthplace: Unknown

16. Informant: William E. Martin

Address: Rockville, Md (Haiti)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 4, 1945 (month) (day) (year)

Cemetery or crematory: Haiti

Location: Rockville, Md

18. Funeral director: Robert L. Swayden

Address: 246 N. Wash. St. Rockville, Md

19. 2/4 (Date rec'd by registrar) 1945 Joaquin D. Hutton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 1 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 30 1945, to Feb. 1 1945

and that I last saw him alive on Jan. 30 1945

	DURATION
Immediate cause of death: Myocardial failure	Few days
Due to:	
Due to: Senility, Senile dementia	Several years
Other conditions: Arteriosclerosis, Malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm A. Faithauer M.D. M. D. or other

Address: Rockville, Md Date signed: 2/2/45

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

01902

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville (If outside city or town limits, write RURAL and give nearest town)
Street No.: Box 173 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clement Martin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Janie
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 1880

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
64	10			

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Thomas Martin
13. Birthplace: Rockville, Md.

MOTHER
14. Maiden name: Brown
15. Birthplace: Washington, D.C.

16. Informant: Bernice Briley
Address: Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 20, 1945 (month) (day) (year)
Cemetery or crematory: Haiti Cemetery
Location: Rockville, Maryland

18. Funeral director: Robert L. Snouffer
Address: 246 N. Wash. St. Rockville

19. 2/20 1945 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14, 1945 at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-3- 1945, to 2-14- 1945
and that I last saw h alive on 19

Immediate cause of death	DURATION
Congestive heart failure	
Due to: Uremia	
Chronic nephritis. Cause?	
Due to: Duration: Indefinite	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm W. Welch M.D. or other
Address: 104 S. Wash. - Rockville Md. Date signed: 2/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

01903

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
7201 Takoma Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7701- TAKOMA AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SAMUEL K. McCALL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: PAULINE

7. Birth date of deceased (mo., day, yr.): APRIL 9, 1876

6.(c) If alive, give age ..... years

8. AGE:

Years	Months	Days	If less than one day
68			..... hrs. ..... min.

9. Birthplace: PA. (Town, county, and state)

10. Usual occupation: LAWYER

11. Industry or business

FATHER — 12. Name: HUGH McCALL ✓

13. Birthplace ✓

MOTHER — 14. Maiden name ✓

15. Birthplace ✓

16. Informant: MRS W. G. CAPTELL
Address: 7701- TAKOMA, AVE.

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof 2-23-45 (month) (day) (year)

Cemetery or crematory
Location: Washington, D.C.

18. Funeral director: The S. H. Hines Co.
Address: 2901-14 St. Wash. D.C.

19. Feb 23 19 45 (Date rec'd by registrar) J. William Doyle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23 19 45 at 12:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to: Cardiac degeneration	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Bronchart M.D. Dep. Med. Exam M. D. or other
Address: Frederick, Md. Date signed 2-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

01904

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Ohio County:

City or town: Euclid,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5232 Kynd So.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

MC CARTIN, Clifford Clarence, Lt.(jg) O-V(S) USNR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

8.(b) Name of husband or wife: Mrs. Betty McCartin

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1 August 1906

8. AGE: Years	Months	Days	If less than one day
38	6	22	hrs. min.

9. Birthplace: Ill.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER — 12. Name: John McCartin

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Jennie Wright

MOTHER — 15. Birthplace: Ill.

16. Informant: Wife: Mrs. Betty McCartin

Address: 5232 Kynd So., Euclid, Ohio

17. burial (Burial, cremation, or removal. Which?) Date thereof: 3-14-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. Chambers W. W. Chambers

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 3-12 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23 1945 at Bethesda, Md.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Patient to Corpse 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia by Strangulation (Suicide)	Immed.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 2-23-45

Where did injury occur? Bethesda (City or town) Montg. (County) Md. (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brockett M. D. M. D. or other

Address: Gaithersburg Md Date signed: 3-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

01905

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Sanitarium + Hospital

How long in hospital or institution? 3 mo. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 608 Carroll ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. James McGowan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Mary Cannaday (Deceased) 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 23, 1873

8. AGE: Years	Months	Days	If less than one day
71	3	26	hrs. min.

9. Birthplace: New York City, N.Y. (Town, county, and state)

10. Usual occupation: Artist

11. Industry or business: Government Worker

FATHER — 12. Name: —

13. Birthplace: —

MOTHER — 14. Maiden name: —

15. Birthplace: —

16. Informant: Records, Wash. Sam. + Hospital

Address: Takoma Park, Md.

17. removal (Burial, cremation, or removal. Which?) Date thereof Feb. 18 1945 (month) (day) (year)

Cemetery or crematory: Washington, D.C.

Location: " "

18. Funeral director: J. Wm. Lee Funeral Co.

Address: 300-4 st N.E. - Wash. D.C.

19. Feb. 18 1945 Josephine M. Schaffe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18 1945, at 3 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 26 1944 to Feb. 18 1945 and that I last saw h. alive on Feb. 17 1945

Immediate cause of death	DURATION
Asthma (bronchial)	40 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. T. McNeill, M.D.

M. D. or other

Address: Silver Spring, Md. Date signed 2-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01906

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery County

City or town: Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 15 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium

How long in hospital or institution? 1 month 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County: Columbia

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1335 Hemlock St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mildred Miller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: John Charles Miller

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): January 7, 1900

8. AGE: Years	Months	Days	If less than one day
45 yrs	1	13	...hrs. ...min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER — 12. Name: Lowell C. Shattuck

FATHER — 13. Birthplace: Lowell, Mass.

MOTHER — 14. Maiden name: Fannie Duly

MOTHER — 15. Birthplace: Duly, Maryland

16. Informant: Husband & Sanitarium Records

Address: Takoma Park. Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/20/45 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: S.H. Hines Co

Address: 2901 - 14th St. N.W., Washington, D.C.

19. Feb 20 19 45 (Date rec'd by registrar) J. Wilson Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20 1945 at 10 37 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Feb 20 1945 and that I last saw h.. alive on Feb 20 1945.

	DURATION
Immediate cause of death: Circulatory Failure	20 hrs.
Due to: Cerebral Hemorrhage	6 da.
Due to: Acute Hypertension with nervous tension	7 da. ago
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: S. Arthur Kotz M.D. M. D. or other

Address: Wash. San. and Hospital Date signed 2/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

01907

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ yrs

Hospital, Institution, or street address where death occurred:
402 Monroe St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montg.

City or town: Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 402 Monroe St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Walter Wilson Nicholson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Leyndall V. Nicholson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 27 - 1897

8. AGE: Years	Months	Days	If less than one day
47	7	16	..... hrs. ..... min.

9. Birthplace: Monty. Co. Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER — 12. Name: Reuben M. Nicholson

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Florence Watkins

MOTHER — 15. Birthplace: Maryland

16. Informant: Leyndall V. Nicholson

Address: 402 Monroe St. Rockville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/14/45 (month) (day) (year)

Cemetery or crematory: Cedar Grove Salem Church Cem.

Location: Cedar Grove, Md

16. Funeral director: Wm Reuben Dunphrey

Address: 7557 Wis. Ave. Bethesda, Md

19. 2/13/45 (Date rec'd by registrar) Josephine D. Foster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 12 1945 at 8:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. Case 19..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Coronary occlusion — DURATION: dead suddenly

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.
Dep. Med. Exam. M. D. or other

Address: Gaithersburg, Md Date signed: 2-12-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

01998

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Rural - Germantown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ years
Hospital, institution, or street address where death occurred:
Seneca
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: R.F.D., Germantown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Seneca
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George Henry Nickens

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Martha Jane
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10-9-66

8. AGE: Years	Months	Days	If less than one day
78	4	4	..... hrs. ..... min.

9. Birthplace: Lloyds, Essex Co., Va.
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: William Nickens
13. Birthplace
MOTHER 14. Maiden name: Mary Monday
15. Birthplace
16. Informant: Montgomery County Welfare Board
Address: Rockville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 15, 1945 (month) (day) (year)
Cemetery or crematory: Norbeck, Cemetery
Location: Norbeck, Maryland
18. Funeral director: Robert L. Snyder
Address: 246 N. Wash. St. Rockville
19. Feb 14 1945 Alvada L. Cook, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/13/45, 1945, at 4 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944 to Feb - 11 - 1945
and that I last saw him alive on Feb - 11 - 1945

Immediate cause of death	DURATION
Acute heart failure	2 days
Due to: Interstitial Nephritis	7 mo.
Due to: Senility	6 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William C. Miller, M.D.
M. D. or other
Address: Feb - 13 - 45 Gaithersburg, Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

01909

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 30 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 905 City Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John A. Norris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hannah J. Norris

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 13, 1888

8. AGE:	Years	Months	Days	If less than one day
	56	6	8	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER

12. Name: John William Norris

13. Birthplace: Maryland

MOTHER

14. Maiden name: Ida Mathews

15. Birthplace: Maryland

18. Informant: Nellie Mae Norris

Address: 905 City Rd., Rockville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 2/24/45 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Rockville, Md.

18. Funeral director: Wm Reuben Dumphrey

Address: Rockville, Maryland.

19. 2/22 19 45 (Date rec'd by registrar) Wm E. Jordan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 21, 19 45, at 3:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Intracerebral Hemorrhage, Massive	
Due to: Cerebral arteriosclerosis + Hypertension	
Due to:	
Other conditions: Bronchial asthma	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Richard E. Kelso, M.D. M. D. or other

Address: 8600 Old Georgetown Rd Bethesda, Md. Date signed: 2-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (924)

CERTIFICATE OF DEATH

01910

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 507 CARROLL AVE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ORA OSTRANDER.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	WIDOWED

6.(b) Name of husband or wife: Mrs. OSTRANDER
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): APRIL 3, 1854.

8. AGE: Years	Months	Days	If less than one day
90	10	24	..... hrs. ..... min.

9. Birthplace: HOLLY, MICHIGAN.
(Town, county, and state)
10. Usual occupation: AT HOME
11. Industry or business

FATHER
12. Name: W. W. LOCKWOOD
13. Birthplace: MICHIGAN.

MOTHER
14. Maiden name: ?
15. Birthplace

16. Informant: CLARA WITZKE.
Address: 507 CARROLL AVE.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: MAR. 3, 1945 (month) (day) (year)
Cemetery or crematory: GLENWOOD CEMETERY
Location: WASHINGTON, D. C.

18. Funeral director: Arthur T. Ballew
Address: 2[illegible] Carroll St. N.W., Takoma Park, D.C.

19. Feb 25 1945 (Date rec'd by registrar) J. William Doll Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27th 1945, at 150 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1936, to Feb 27, 1945
and that I last saw h[illegible] alive on [illegible] 19[illegible]

	DURATION
Immediate cause of death: Senility (91 yrs) and	
Myocardial Failure	
Due to: Chr. myocardial degeneration	9 yrs
Valvular insufficiency	9 yrs.
Due to	
Other conditions: Bronchial asthma	9 yrs
Chr. Bronchitis	9 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Lead H. Calvert M.D.
Address: 894 Ga Ave. Silver Spring Md. M. D. or other
Date signed: 2-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1572)

CERTIFICATE OF DEATH

01911

Reg. Diat. No. 223-

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: TAKOMA PARK, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
WASHINGTON SANITARIUM
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: PRINCE GEORGES.
City or town: HAMPSHIRE KNOLLS.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6513 Flanders Drive.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: JAMES HUGH PARSONESE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): APRIL 14, 1944.

8. AGE: Years	Months	Days	If less than one day
	9	29	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER 12. Name: PETER PARSONESE.
13. Birthplace: NEWARK, N.J.

MOTHER 14. Maiden name: MARY McBRIDE
15. Birthplace: MOREA, PENNA.

16. Informant: PETER PARSONESE
Address: 6513 FLANDERS DRIVE, HAMPSHIRE KNOLLS.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: FEB. 16, 1945. (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director: J. Arthur Fallers.
Address: 254 Carroll St. Takoma Park, D.C.

19. Feb. 14th 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13 1945, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 14 1944 to Feb. 13 1945 and that I last saw him alive on Feb. 13 1945

	DURATION
Immediate cause of death: Cardiac dilatation as result of congenital heart disease	6 hrs.
Due to: Acute bronchitis	2 days
Due to:	
Other conditions: Weak debilitated infant	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wm A Thomson M.D. M. D. or other
Address: 113 Carroll St. Takoma Park, D.C. Date signed: Feb. 13, '45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (aa)

01912

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since October 1944
Hospital, Institution, or street address where death occurred:
N 1608 No. Springwood Drive
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mass County: Norfolk
City or town: Quincy
(If outside city or town limits, write RURAL and give nearest town)
Street No. 94 Upland Road
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Caroline Georgianna Picard

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 27 April 1885

8. AGE: Years	Months	Days	If less than one day
59	9	27	..... hrs. ..... min.

9. Birthplace: Rèviere du Loup, P.Q. Canada
(Town, county, and state)
10. Usual occupation: Bookkeeper
11. Industry or business

FATHER
12. Name: Arthur Picard
13. Birthplace: Canada

MOTHER
14. Maiden name: Elsie M. Grenier
15. Birthplace: Canada

16. Informant: Major C. M. Peters, M.C. USArmy
Address: 1608 No. Springwood Drive Silver Spr Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Mt. Walliston
Location: Quincy, Norfolk Co. Mass
18. Funeral director: Wone & Dunphey
Address: 8434 Ga. Ave. Silver Spring, Md.
19. Feb 25 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 February 1945 at 3:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 24 1944 to 24 Feb 1945
and that I last saw her alive on 24 February 1945
Immediate cause of death: Peripheral vascular collapse — DURATION: hours
Due to: Carcinomatosis — DURATION: .....
primary site probably pelvis — DURATION: months
Due to: Hypernephroma of left kidney — DURATION: .....
Duration: one years — DURATION: .....
Other conditions: ..... — DURATION: .....
(Include pregnancy within 3 months of death)
Major findings of operations: no
Date of op. .....
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Carey M Peters Maj MC
M. D. or other
Address: Walter Reed Gen Hospital Date signed .....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

01913

CERTIFICATE OF DEATH

Reg. Diat. No. 212

1. PLACE OF DEATH:

County Montgomery

City or town Dickerson - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Monty.

City or town Dickerson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Walter S. Poole Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27 - 1930

8. AGE:

Years	Months	Days	If less than one day
14	0	28	hrs. min.

9. Birthplace Dickerson, Monty. Md.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name Walter S. Poole

13. Birthplace Md.

MOTHER 14. Maiden name Mabel Hungerford

15. Birthplace Md.

16. Informant Walter S. Poole.

Address Dickerson. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 16 45 (month) (day) (year)

Cemetery or crematory Monocacy

Location Beallsville, Md.

18. Funeral director Wm. B. Hilton

Address Barnesville. Md.

19. Mar. 15 1945 (Date rec'd by registrar) Mrs. C.C. Hilton (Registrar)

By Mrs. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exr. 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia	
Due to Drowning (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 2-25-45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury drowning Injured at work? no

23. SIGNATURE Fred J. Brosnahan M.D.

Dep. Med. Exam. M. D. or other

Address Gaithersburg Md Date signed 3-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01914

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: near Edmonston INCORP
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Near Edmonston INCORP
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Hattie L. Prather

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1895 July 5

8. AGE: Years	Months	Days	If less than one day
49	7	22	hrs. min.

9. Birthplace: Montgomery Co Md
(Town, county, and state)
10. Usual occupation: Nurse
11. Industry or business: Own
FATHER 12. Name: Levi Prather
13. Birthplace: Montgomery Co Md
MOTHER 14. Maiden name: Martha J. Simpson
15. Birthplace: Montgomery Co Md
16. Informant: Lucy Prather
Address: Gaithersburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 2 1945 (month) (day) (year)
Cemetery or crematory: Brookmont Md
Location: Cabin John Md
18. Funeral director: Roy W. Barber
Address: Laytonsville Md
19. Mar 4 1945 (Date rec'd by registrar) L. D. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27 1945 at 6 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 7 1945, to Feb 27 1945 and that I last saw h.e alive on Feb 24 1945

Immediate cause of death	DURATION
Coronary Occlusion	Minutes
Due to: Diabetes	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Vernon H Orgain M. D. (M. D. or other)
Address: Laytonsville Md Date signed: Mar 12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

01915

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Monty

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hr

Hospital, Institution, or street address where death occurred:

Suburban Hosp.

How long in hospital or institution? 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4435 Hayes St. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Peter Randall

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	married

6.(b) Name of husband or wife: Mattie M Randall

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 14, 1866

8. AGE: Years: 78? Months: Days: If less than one day: hrs. min.

9. Birthplace: D.C. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business: government clerk

FATHER 12. Name: Henry Randall

FATHER 13. Birthplace: Anne Arundel Co.

MOTHER 14. Maiden name: Isbella Hawkins

MOTHER 15. Birthplace: Anne Arundel Co.

16. Informant: Mattie M Randall

Address: 4435 Hayes St. N.E. West Dr

17. Removal (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: J. B. Johnson

Address: 467 - N St NW

19. 2-26-45 19.. (Date rec'd by registrar) W E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 25 19 45, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam Case 19..

and that I last saw h alive on 19..

	DURATION
Immediate cause of death: Cerebral hemorrhage	6 hrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Burchart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md Date signed: 2-25-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

01916

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hours

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ____ County: ____

City or town: Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4404 Yuma Street, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Margaret Catherine RAUBER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	

6.(b) Name of husband or wife: ____

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 21, 1945

8. AGE: Years	Months	Days	If less than one day
			five hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: ____

11. Industry or business: ____

FATHER

12. Name: Louis J. RAUBER, Comdr. USN

13. Birthplace: New York

MOTHER

14. Maiden name: Margaret Cranford

15. Birthplace: Washington, D. C.

16. Informant: Father: Comdr. Lewis J. Rauber

Address: 4404 Yuma Street, N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2-22-45 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Washington, D. C.

18. Funeral director: W. W. CHAMBERS RDR

Address: 1400 Chapin St., N. W.

19. Feb. 21 19 45 Mary Charlotte Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 21 19 45 at 2:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 21 19 45 to Feb. 21 19 45 and that I last saw h. 34 alive on Feb. 21 19 45

Immediate cause of death	DURATION
Prematurity	
Due to: Preterm	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: H. S. [illegible], Comdr. M. D. or other

Address: U.S.N.H., Bethesda, Md. Date signed 2/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01917

Reg. Dist. No. 2/3

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville Md (114-W. Mouly Ave)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs -

Hospital, institution, or street address where death occurred:

Rockville, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Rockville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 114- W. Mouly Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rose M. Ruark

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W.	widowed

6.(b) Name of husband or wife: Mayhew

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1855

8. AGE:

Years	Months	Days	If less than one day
89	3	25	hrs. min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Miller

11. Industry or business

FATHER

12. Name: Samuel W. Magruder

13. Birthplace: Monty. Co. Md.

MOTHER

14. Maiden name: Martha Riley

15. Birthplace: Monty. Co. Md.

16. Informant: Miss Daisey Magruder, Niece

Address: Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/7/45 (month) (day) (year)

Cemetery or crematory: Forden Park Cemetery

Location: Baltimore Md.

16. Funeral director: Wm Reuben Dunphrey

Address: 7557 Wis. Ave. Bethesda, Md

19. 2/5 (Date rec'd by registrar) 1945 Josephine D Hutton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to Feb. 4 1945 and that I last saw her alive on Feb. 4 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	1 week
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Esther F. Kuhn M.D. M. D. or other

Address: Rockville, Md. Date signed 2/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01918

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Chas Scott

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Annie Scott
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1870

8. AGE: Years: 74 | Months: 9 | Days: | If less than one day: hrs. min.

9. Birthplace (Town, county, and state): Montgomery Co., Md.

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Michael Scott
13. Birthplace: Howard Co. Md.

MOTHER
14. Maiden name: Margaret Howard
15. Birthplace: Howard Co. Md.

16. Informant: Annie Scott (wife)
Address: Sandy Spring, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 10, 1945 (month) (day) (year)
Cemetery or crematory: Sandy Spring
Location: Sandy Spring, Md

18. Funeral director: Robert L. Dawson
Address: 246. N. Wash. St. Rockville

19. Feb 10 1945 Gertrude B. Lawson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 6 - 1945 at 9 45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 - 1944 to Feb 6 - 1945 and that I last saw him alive on 2 - 4 - 1945

Immediate cause of death	DURATION
Chronic Valvular Heart	
disease with Hypertension	9 Mo
Due to: sion	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas E Tomlinson M. D. or other
Address: Sandy Spring Md Date signed: 2-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

01919

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Emory Grove Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Forty Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgo
City or town Emory Grove Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) No
2.(a) If veteran, name war

3.(a) FULL NAME Robert H. Sellman

3.(b) Social Security Number 218-20-1347

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	married

6.(b) Name of husband or wife Mamie S Sellman
6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) May 25 1888

8. AGE: Years	Months	Days	If less than one day
57	8	19	hrs. min.

9. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Building
FATHER 12. Name Henry Sellman
13. Birthplace Montgomery Co Md
MOTHER 14. Maiden name Ellen Fitzhugh
15. Birthplace Montgomery Co Md
16. Informant Mamie S Sellman
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 15 1945 (month) (day) (year)
Cemetery or crematory Emory Grove Md
Location Near Gaithersburg Md
18. Funeral director Roy W Barber
Address Poolesville Md
19. Feb 13 1945 Abbie L Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1945, at 1:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944 to Feb 12 1945
and that I last saw h alive on Feb 12 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	18 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J Brockhurst Dep. Med. Exam M. D. or other
Address Gaithersburg Date signed 2-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01920

CERTIFICATE OF DEATH

Reg. Diat. No. 212.

1. PLACE OF DEATH:

County: Montgomery

City or town: Poolesville, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years.

Hospital, institution, or street address where death occurred: Poolesville Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery.

City or town: Poolesville Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Isreal Simms

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Married.

6.(b) Name of husband or wife: Ella F. Simmes.

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): (7) 6 1868

8. AGE: Years ✓ | Months: June | Days | If less than one day: ...hrs. ...min.

9. Birthplace: Montgomery
(Town, county, and state)

10. Usual occupation: Labor,

11. Industry or business

FATHER
12. Name: John Isreal Simmes
13. Birthplace: Montgomery

MOTHER
14. Maiden name: Amanda Lee
15. Birthplace: Montgomery.

16. Informant: Ella F. Simmes.
Address: Poolesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 13. 46
(month) (day) (year)

Cemetery or crematory: Martinsburg Md.

Location: near Dickinsons.

18. Funeral director: Clarence H Davis.

Address: Poolesville md

19. Feb 13 1945 Charles E Fox
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 — 1945, at 5 40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/4 1945 to 2/10 1945 and that I last saw him alive on 2/10 1945

Immediate cause of death	DURATION
Lobar Pneumonia	6 Days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: B. D. White, M.D.
M. D. or other

Address: Poolesville, md. Date signed: 2/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01921

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery Co.

City or town: Bethesda - Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 10 minutes.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Wash. D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 64 Bryant St NW

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: ~~Henry~~ Sisson (Herbert)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: (Mrs.) Viola Sisson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 29 - 1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	8	20		

9. Birthplace: Westmoreland Co - Md.

(Town, county, and state)

10. Usual occupation: Meat cutter

11. Industry or business

FATHER

12. Name: George S. Sisson

13. Birthplace: Virginia.

MOTHER

14. Maiden name: ? Cabbe.

15. Birthplace: Virginia

16. Informant: Mrs. Viola Sisson - wife

Address: 64 Bryant St. N.W. Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director: The S. N. Young Co

Address: 2901 - 14 St NW

19. 2/19 19 45 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18 19 45, at 1 30 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept Med. Exam case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral hemorrhage	1/2 hr.
Due to: Lobar pneumonia	3 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brockhurst M.D. M. D. or other

Address: Hagerstown Md Date signed 2-19-45

M.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

01922

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Inc.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charlotte Sloane

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White.	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1900

8. AGE: Years	Months	Days	If less than one day
44	6	3	hrs. min.

9. Birthplace Roanoke, Virginia (Town, county, and state)
10. Usual occupation Nurses Aide.
11. Industry or business
FATHER 12. Name Fletcher Sloane
FATHER 13. Birthplace Virginia
MOTHER 14. Maiden name Cherry Hale
MOTHER 15. Birthplace Virginia
16. Informant Hospital records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/12/45 (month) (day) (year)
Cemetery or crematory Rockville Cem
Location Md
18. Funeral director Wm. Reuben Dunnigan
Address 7557 Wis. ave. Bethesda Md.
19. Feb. 9 1945 (Date rec'd by registrar) Dr. Trudie B. Lawton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1945, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1944 to Feb. 7 1945 and that I last saw her alive on Feb. 7 1945

Immediate cause of death	DURATION
Carcinomee ?	
Due to the abdomial organs following	1 yr.
Due to Carcinoma of breast	4 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas C Tunnicliff M. D. or other
Address Sandy Spring Md Date signed 2-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

01923

CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

~~Hospital, institution, or~~ street address where death occurred: 9405 Saybrooke Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Connecticut County: Windham

City or town: Willimantic (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war — V

3. (a) FULL NAME: Frederick Smith

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of ~~husband or~~ wife: Elsie Winifred Foster Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 26, 1868

8. AGE: Years	Months	Days	If less than one day
76	1	10	..... hrs. ..... min.

9. Birthplace: Mass. (Town, county, and state)

10. Usual occupation: Retired Employee of the

11. Industry or business: Finance Dept of New York City

FATHER 12. Name: Rev Elijah F. Smith

13. Birthplace: England

MOTHER 14. Maiden name: Lucina Foster

15. Birthplace: England

16. Informant: Frank Foster Smith

Address: 9405 Saybrooke Ave., S.S. Md.

17. Transportation + Burial thereof Feb. 7, 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery ~~or crematory~~: Willimantic Cemetery

Location: Willimantic, Windham Co., Conn.

18. Funeral director: Waxnex E. Pumphrey

Address: Silver Spring, Md.

19. Feb. 7th 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6 1945 at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Fred J. Borchert M.D. Deputy Med. Examiner M. D. or other

Address: Hartford Conn. Date signed: 2-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01924

CERTIFICATE OF DEATH

Reg. Dist. No. 123

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 YRS.
Hospital, institution, or street address where death occurred:
10 JEFFERSON AVE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 JEFFERSON AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME SARAH SMITH

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	WIDOWED.

6.(b) Name of husband or wife: FREDERICK WM. C. SMITH
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JAN. 11, 1871

8. AGE: Years	Months	Days	If less than one day
74	1	7	..... hrs. ..... min.

9. Birthplace: SOUTH WALES, ENGLAND.
(Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business: OWN HOME.

FATHER
12. Name: GEORGE TUCKWELL
13. Birthplace: ENGLAND.

MOTHER
14. Maiden name: CAROLINE GOODE.
15. Birthplace: ENGLAND.

16. Informant: MRS. FRED TAYLOR
Address: 113 SHERMAN AVE. TAKOMA PARK, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: FEB. 21, 1945. (month) (day) (year)
Cemetery or crematory: CEDAR HILL CEMETERY
Location: PENNSYLVANIA AVE SE.

18. Funeral director: J. Arthur Tallery
Address: 254 Carroll St. N.W. Takoma Park D.C.

19. Feb 15 1945 (Date rec'd by registrar) J. Arthur Tallery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEBRUARY 18, 1945, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5 1945 to Feb. 18 1945 and that I last saw h... alive on Feb. 17 1945

Immediate cause of death	DURATION
Carcinoma - stomach	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: J. N. Bullers M. D.
M. D. or other
Address: 766 Roach-Ch. Rd Date signed: Feb. 18

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13K)

CERTIFICATE OF DEATH

D1925

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 39 years
Hospital, institution, or street address where death occurred: 400- West Montg Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 400- West Montg Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ada Ruth Thompson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Arthur Thompson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 8 - 1868

8. AGE: Years	Months	Days	If less than one day
76	6	20	hrs. min.

9. Birthplace: Hillsboro - Virginia
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:

FATHER
12. Name: Thomas R Clendening
13. Birthplace: Hillsboro - Virginia

MOTHER
14. Maiden name: Sarah Jane Bartird
15. Birthplace: Bartletons. Va.

16. Informant: Mr Hugh R Thompson
Address: 400 - W Montg Ave Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 21 45 (month) (day) (year)
Cemetery or crematory: Hillsboro Church
Location: Hillsboro - Loudon Co - Va

18. Funeral director: Wm Poulton Dunnington
Address: Rockville - Maryland

19. 3/28/45 (Date rec'd by registrar) Josephine D Hallon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 19 45 at 5-55 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw her alive on Feb 26 19 45

Immediate cause of death	DURATION
Chron Myocarditis	4 mos
Due to: Chronic Nephritis	2 yrs
Due to: Senility	
Other conditions: Senile	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: C E Woods M. D. or other
Address: Rockville Md Date signed: 2/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-C

CERTIFICATE OF DEATH

01926

Reg. Dist. No. 216

1. PLACE OF DEATH:
County MONTGOMERY COUNTY
City or town CHEVY CHASE, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 21 EAST MELROSE STREET, CHEVY CHASE
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 20 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase, Maryland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 21 East Melrose Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: MRS. EUGENIA TINSLEY

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: George A. Tinsley

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 25th, 1855

8. AGE: Years	Months	Days	If less than one day
89			____ hrs. ____ min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Gabriel F. Miller
13. Birthplace: Virginia

MOTHER
14. Maiden name: Willie Howlett
15. Birthplace: Virginia

16. Informant: Mrs. Leslie C. Garnett
Address: 21 East Melrose Street, Chevy Chase

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/5/45 (month) (day) (year)
Cemetery or crematory: Mathews, Virginia
Location: Mathews, Virginia

18. Funeral director: Martin W. Tyson & Co.
Address: 1300 N. Street, N.W.-Wash, D.C.

19. Feb 5 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5th, 1945 19 45, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1945 to Feb 5 1945, and that I last saw h[illegible] alive on Feb 3 1945.

Immediate cause of death: Congestive heart failure — DURATION: 2 days
Due to: Mitral Regurgitation — 6 years
Due to:
Other conditions: Enter-Colitis — 25 days
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Wallace C. Simpson M. D. or other
Address: 1514 - 30th — Date signed Feb 5 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

8012 - BCd
Georgetown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-E)

01927

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
214 Carrol Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 214 Carrol Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: ELIZA E. TURNER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Frank S.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 17th. 1877

8. AGE: Years	Months	Days	If less than one day
67	5	5	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Levin Clark
13. Birthplace: Maryland

MOTHER
14. Maiden name: Frances Barnes
15. Birthplace: Maryland

18. Informant: Frank L. Turner

Address: 407 Granville Drive. Sil. Spg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 26th. '45 (month) (day) (year)

Cemetery or Crematory: Grace Episcopal Church

Location: Silver Spring, Md.

18. Funeral director: Wane & Conaway.

Address: 8434 Ga. Ave. Silver Spring, Md.

19. 2-24 1945 (Date rec'd by registrar)

H. Wendley Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/22/45 19..... at 5:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1939 to Feb. 22 1945

and that I last saw h.er alive on February 22 1945

Immediate cause of death	DURATION
Heart Failure	
Carcinoma of Liver.	2 yrs.
Splenomegaly	1 year
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State) —

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: W B Wanley M.D. M. D. or other

Address: 943 Bonifant St. Date signed: 2/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01928

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Turner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 1st 1867

8. AGE: Years	Months	Days	If less than one day
78			..... hrs. ..... min.

9. Birthplace: Fairfax County, VA. (Town, county, and state)
10. Usual occupation: Home keeper.
11. Industry or business
12. FATHER — Name: Henry Johnson.
13. Birthplace: Md.
14. MOTHER — Maiden name: Marie Weldon.
15. Birthplace: Prince George Co., Md.
16. Informant
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 21 1945 (month) (day) (year)
Cemetery or crematory: Forest Glen Cemetery
Location: Forest Glen, Maryland
19. Funeral director: Robert L. Snowden
Address: 246 N. Wash. St. Rockville
19. Mch 20 1945 Josephine M. Schaeffer Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 17, 1945, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13, 1945, to Feb. 17, 1945
and that I last saw h.. alive on Feb. 17, 1945

Immediate cause of death	DURATION
Congestive heart failure	24 hr.
Due to: Lobar pneumonia	5 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. B. Little M.D.
M. D. or other
Address: 6911 S. 16th St. Washington, D.C. Date signed: Feb. 17, 1945.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01929

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 59 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Poolesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ella Umpstead

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1868

8. AGE: Years	Months	Days	If less than one day
76	5	29	hrs. min.

9. Birthplace Bayda, Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Richard Umpstead
13. Birthplace Bayda, Maryland.

MOTHER 14. Maiden name Frances Austin
15. Birthplace Bayda Maryland.

18. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 28, 1945 (month) (day) (year)
Cemetery or crematory Monocacy
Location Beallsville, Md.
18. Funeral director Wm. B. Kilgore
Address Barnesville, Md

19. 2-26- 19 45- (Date rec'd by registrar) M S Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26. 19 45, at 7 20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26, 1945 19 , to 19
and that I last saw h~~e~~ alive on 19

Immediate cause of death	DURATION
Diabetis mellitus	
Due to	
Due to	
Other conditions Asteriosclerosis senility	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. Estelle Shull Jr M. D. or other
Address Suburban Hospital Date signed 2-26-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-c

01930

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Monty. Co. General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Alfred Walker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	married

6.(b) Name of husband or wife: Ida Walker
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): May 10. 1885

8. AGE: Years: 60 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: montgo Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Remus Walker
13. Birthplace: Montgo. Co. Md.

MOTHER
14. Maiden name:
15. Birthplace

16. Informant: Ida Walker
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 17, 1945 (month) (day) (year)
Cemetery or crematory: Sandy Springs
Location: Sandy Springs, Md.

18. Funeral director: Robert L. Snowden
Address: 246 N. Wash. St. Rockville

19. 2-15- 1945 Gertrude B. Lawson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 13 1945, at 9.30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1944 Med Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
exposure	
Due to acute alcoholism	12 hrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md. Date signed: 2-13-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

01931

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Dickerson - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Monty

City or town: Dickerson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME David Warfield

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29 - 1928

8. AGE: Years	Months	Days	If less than one day
16	4	26	hrs. min.

9. Birthplace: Dickerson, Monty, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: William Warfield

13. Birthplace: Md.

MOTHER 14. Maiden name: Betty Hardy

15. Birthplace: Md.

16. Informant: Mrs. Wm. Warfield

Address: Dickerson. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 (month) 15 (day) 45 (year)

Cemetery or crematory: Monocacy

Location: Beallsville, Md.

18. Funeral director: Wm. B. Hilton

Address: Barnesville. Md.

19. Mar. 15 19 45 (Date rec'd by registrar) Mrs. C. C. Hilton Registrar By Mrs. W. B. H.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 25 19 45 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 to Case 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia (accidental)	—
Due to: Submersion	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of 2-25-45

Where did injury occur? Dickerson (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Borchard M. D. M. D. or other

Address: Barnesville Md Date signed 3-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01932

CERTIFICATE OF DEATH

Reg. Diat. No. 716

1. PLACE OF DEATH:
County Monty.
City or town Bkeby Chase Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, Institution, or street address where death occurred: Home - 4520 Ridge St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Monty.
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4520 Ridge St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Majorie B. Weisbrodt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married.

6.(b) Name of husband or wife Paul E.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Oct. 15, 1922

8. AGE: Years	Months	Days	If less than one day
22	4	27	..... hrs. ..... min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name Richard F. Clagett
13. Birthplace Md.
MOTHER 14. Maiden name Hester Mary O'Neal
15. Birthplace Maryland
16. Informant Hazel O'Neal
Address 4520 Ridge St. Ch. Ch.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/12/45 (month) (day) (year)
Cemetery or crematory Rockville Cem. Assoc.
Location Rockville, Md.
18. Funeral director Wm Reuben Pamphrey
Address 7557 Wis. Ave. Bethesda, Md.
19. 2/12 1945 Wm E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1944 to Feb. 12 1945 and that I last saw her alive on Feb. 11 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	15 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Winthrop Peabody (M. D. or other)
Address 1746 K St. N.W. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Permit No. 535

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01933

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ hrs

Hospital, institution, or street address where death occurred: 22 E. Bradley Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington, D. C

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3617 13th St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Elmer B Weston

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) About 1875

8. AGE: Years	Months	Days	If less than one day
About 70			hrs. min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business

FATHER

12. Name: unknown

13. Birthplace: unknown

MOTHER

14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Mrs. Hambright

Address: 1368 Columbia Rd., N. W.

17. Disinterment (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Coltsville Pa. Cem

Location: Pennsylvania.

18. Funeral director: Wm Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. Feb 8 1945 (Date rec'd by registrar) Wm E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 5, 1945, at 8:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1944 to Feb 5 1945 and that I last saw him alive on Feb 5 1945

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. M. D. or other

Address: Gaithersburg, Md. Date signed 2-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01934

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural - Rockville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
Waverley Sanitarium

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rural - Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edson Lane
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
Mary Clark Werer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 8, 1857

8. AGE:

Years	Months	Days	If less than one day
87	2	2	..... hrs. ..... min.

9. Birthplace: Watertown N.Y.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Don't know
13. Birthplace:

MOTHER
14. Maiden name: Don't know
15. Birthplace:

16. Informant: Cora Peck Erikson, niece
Address: Edson Lane, Rockville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/16/45 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: The S. H. Hines co
Address: 2901-14-st N.W. Washington D.C.

19. 2/16 1945 (Date rec'd by registrar) Mrs E Dobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 1944 to Feb. 10 1945 and that I last saw h[illegible] alive on Feb 10 1945.

	DURATION
Immediate cause of death: Myocardial failure	2wks
Due to: Chronic interstitial nephritis	5 years
Due to: arteriosclerosis	
Due to: albuminuria	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm A. Settlemyer M.D.
M. D. or other

Address: Rockville, Md. Date signed: 2/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

D1935

Reg. Dist. No. 716

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7731 Georgetown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Archie Williams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife Madeline
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov-11, 1916

8. AGE: Years 28 | Months 2 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Cab driver
11. Industry or business

FATHER
12. Name O-K. Williams
13. Birthplace Virginia

MOTHER
14. Maiden name Dola Brooks
15. Birthplace Virginia

16. Informant Madeline I. Williams
Address 7731 Georgetown Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/11/45 (month) (day) (year)
Cemetery or crematory Mangs Virginia
Location Virginia

18. Funeral director Wm Reuben Pumphrey
Address 7557 Wis. Ave. Bethesda

19. 2/10 (Date rec'd by registrar) 19 45 Wm E Jobbins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 19 45 at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6 19 45 to Feb 8 19 45 and that I last saw h.. alive on Feb 8 19 45

Immediate cause of death	DURATION
Lobar pneumonia	3 days
Due to	
Due to	
Other conditions Fatty degeneration of liver	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul Hunton M.D.
M. D. or other
Address 7425 Wisconsin Date signed 2/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

01936

Reg. Dist. No. 212

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Laytonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Marie Irene Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Married

6.(b) Name of husband or wife: John A. Williams

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Feb. 8 - 1903

8. AGE: Years	Months	Days	If less than one day
41	11	23	hrs. min.

9. Birthplace: Nebo, Smith Co., Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Miller Creager

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Minnie Fulchter

MOTHER — 15. Birthplace: Virginia

16. Informant: John A. Williams

Address: Beallsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2 4 '45 (month) (day) (year)

Cemetery or crematory: Bethany Cem.

Location: Ceres, Virginia

18. Funeral director: Wm. B. Milton

Address: Barnesville, Md.

19. 2/2/45 (Date rec'd by registrar) 19 Mrs. C. C. Hilton By Mrs. C.C.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 1st 1945, at 3 25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/20 1944, to 2/1 - 1945

and that I last saw h-- alive on 2/1 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	3 hrs.
Due to: arteriosclerosis & hypertension	14 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: B. D. White, MD M. D. or other

Address: Barnesville, Md. Date signed 2/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

1937

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5532 Manning Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Frederick Wulff

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Susan
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept-6, 1868

8. AGE: Years	Months	Days	If less than one day
75	4	27	____ hrs. ____ min.

9. Birthplace Sweden (Town, county, and state)
10. Usual occupation Helper
11. Industry or business
FATHER 12. Name Carl Wulff
FATHER 13. Birthplace Germany
MOTHER 14. Maiden name Amelia Anderson
MOTHER 15. Birthplace Sweden
16. Informant Mrs. W. H. Jamison (daughter)
Address 5532 Manning Drive
17. Shipment (Burial, cremation, or removal. Which?) Date thereof 2/3/45 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Altoona, Pa.
18. Funeral director Wm Reuben Funeral Home
Address 7557 Wis. Ave. Bethesda
19. 2-3-45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1945, at 10:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-2-45 19__ to 2/2/45 19__ and that I last saw h. alive on 2/2/45 19__

Immediate cause of death	DURATION
Cerebral Thrombosis	3 wks
Due to	
Advanced Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul Dlanton MD
M. D. or other
Address 7425 Wisconsin Ave. Date signed 2/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

CERTIFICATE OF DEATH

11938

Reg. Dist. No. 21 8

1. PLACE OF DEATH:

County Monty

City or town Gaithersburg R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Monty

City or town Gaithersburg R F D.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Shady Grove Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Helen E Wood

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 16 1898

8. AGE: Years 46 | Months 7 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER 12. Name Edward Johnson

FATHER 13. Birthplace Wash DC

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace

16. Informant Laurene F. Ege

Address Gaithersburg md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 24, 1945 (month) (day) (year)

Cemetery or crematory Maccamellan Cem.

Location Woodstock Va

16. Funeral director Mellinger & Sons.

Address Woodstock Va

19. Feb 21 1945 (Date rec'd by registrar) Abuda L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 19 45, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1944 to Feb 21 1945 and that I last saw h alive on Feb 21 1945

	DURATION
Immediate cause of death Asphyxia by hanging (suicide)	Instantaneous
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 2-21-45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brockhurst M.D.

M. D. or other

Address Gaithersburg md Date signed 2-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-a

CERTIFICATE OF DEATH

1939 2616

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County:
City or town: Staten Island 10
(If outside city or town limits, write RURAL and give nearest town)
Street No. 482 Bard Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Marie Wood

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~: Norman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 30, 1880

8. AGE: Years: 64 | Months: 9 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James Robey
13. Birthplace: Macon, Ga.

MOTHER
14. Maiden name: Catherine O'Donahue
15. Birthplace: Rochester, N. Y.

16. Informant: Mrs. Cortner
Address: 4712 River Rd. N.W. Wash. 16 D.C.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 2/26/45 (month) (day) (year)
Cemetery or crematory: Staten Island N.Y.
Location: Staten Island, N. Y.

18. Funeral director: Wm. Reuben Dimpkey
Address: 7557 Wis. Ave. Bethesda

19. 2/26 1945 Wm E. Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 24, 1945, at 6:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/24 1945, to 2/24 1945
and that I last saw her alive on 2/24 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Keith Cromer M. D. or other
Address: U.S. Naval Hosp. Wash. D.C. Date signed: 2/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15